MHSA Transformation

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

ADULT SYSTEMS OF CARE

REVISED CURTAILMENT /TRANSFORMATION RECOMMENDATIONS MAY 31, 2006

The recommendations below outline approaches that could maximize use of existing resources and promote transformation of current services to those supported by the Mental Health Services Act (MHSA) Community Services and Supports (CSS) Plan. Though developed specifically for the Adult Systems of Care (ASOC) and programs in Service Areas (SA) 6 and 8, these approaches could certainly be modified for additional Service Areas and Bureaus.

ADDITIONAL SERVICE AREA 8 FULL SERVICE PARTNERSHIPS

The plan to transform existing positions at San Pedro Mental Health Center (MHC) to develop a Full Service Partnership (FSP) program will not proceed at this time. Instead, a collaborative approach would be developed among the programs in SA 8. Six staff will be recruited from Long Beach Adult and Asian Pacific MHCs to form a FSP team, as well as five staff from Harbor Adult Outpatient that will join the AMI/ABLE program, building capacity for an additional 100 enrollees in SA 8, the number previously targeted for the proposed San Pedro FSP.

OLDER ADULT FIELD CAPABLE TEAMS

Field Capable Teams to provide specialized services for older adults, funded under the CSS Older Adults plan, will be developed in SAs 6 and 8 through recruitment of five existing staff members from Augustus F. Hawkins (AFH) Adult Outpatient Program. It is envisioned that in addition to seeing older adults in their homes, an integrated team of mental health and primary care providers will deliver services at designated primary care clinics to ensure that both mental and physical health problems are simultaneously addressed. Field capable clinical services are being planned at Harbor-UCLA Medical Center (Harbor), but staffing will not be "transformed" from existing staff but through augmentation upon approval of the plan.

REASSIGNMENT OF EXISTING STAFF TO SERVICE AREA NAVIGATOR TEAMS

Assign existing staff in SAs 6 and 8 to fill the new MHSA positions for Jail Linkage (one PSW II per SA), Housing Services (one Mental Health Services Coordinator II per SA).

REASSIGNMENT OF EMPLOYEES ON EXTENDED/MEDICAL LEAVE

There are currently eight employees in SAs 6 and 8 on medical/administrative leave for extended periods of time of at least six months (see Attachment I). By necessity, their job duties have been covered by other members of their work groups. Accordingly, these individuals could be reassigned to MHSA or other categorically funded programs

upon their return to work, subject to work restrictions. This would allow their current positions to be de-funded.

REASSIGNMENT OF DUAL DIAGNOSIS COORDINATORS

The functions currently performed by the SA Dual Diagnosis Coordinators vary widely and have been under evaluation for transformation. Rather than continuing as single individuals working in isolation, the Coordinators could be assigned to the SA Navigators teams, where their expertise and their functions of linkage, referral and support of co-occurring substance abuse services through training and consultation could be considerably augmented if incorporated into the responsibilities of the SA Navigator Teams.

TRAINING FOR PRIMARY CARE PROVIDERS

One time MHSA funds could support training, development of capacity, and consultation for primary care providers in community based training programs affiliated with AFH and Harbor (T.H.E., Humphrey, Lomita) to provide medication management for current outpatient clients who do not require the services of a psychiatrist or other mental health professionals in order to maintain their stability.

CLIENT –RUN CENTERS

The development of free standing client-run centers will need to go well beyond what is currently funded to support the recovery of clients ready to move to lower levels of care and to shift the locus of care for these clients from outpatient clinics to community-based mutual self help centers. Clients and contract providers are ready to implement such centers (see Attachment II) more broadly than the Wellness Centers envisioned by the stakeholders and included in the CSS plan. In most instances clients accessing these centers would participate in recovery activities and receive support from peers at these free-standing centers, with linkage for medication, physical health and social services as needed. The development of three additional centers in SA 6 and 8 (Inglewood, Lynnwood/Compton and the Crenshaw District) will provide greater local community access with greater responsiveness to the needs of the neighborhoods in which they reside would significantly augment the efforts already in place at the Village in Long Beach and the Pearl Ella Johnson Wellness Center,, currently located within AFH, but funding to relocate this Wellness Center to a free-standing site in the community would enhance functioning and is recommended. One time MHSA funding could support these contracted programs with the longer-range goal of accessing Innovative Program dollars for ongoing funding. In addition, client-run Wellness Centers at San Pedro MHC and Harbor, with medication and support services, will be provided by a nurse from Long Beach MHC and a physician from Harbor.

WORKFORCE DEVELOPMENT AND TRAINING

One time MHSA funds will also be sought to meet the immediate need for training in evidence-based brief treatment models and consultation /training to support the

transformation in clinics that have not benefited from being part of the Big 7 FSP process.

ADDITIONAL CONSIDERATIONS

There are two additional points that warrant consideration. First, it will be necessary for program staff and Information Systems bureau staff to collaborate in the design, development and implementation of a tracking process to ensure that clients expediently move through the system to higher levels of functioning and lower levels of care and avoid getting stuck within any particular phase of treatment. The second point is the need for central administration to participate in the curtailment process to an extent similar to that of the programs. Administrative overhead in the 2006-2007 budget process was increased to 30% and 72 of 258 or 28% of MHSA positions are for Administration. ASOC and SAs 6 and 8 have repeatedly stepped up to meet the budget deficit challenge faced by the Department for both 2005-2006 and 2006-2007. These programs cannot unilaterally absorb all of the needed curtailment without significantly impacting services and irreparably compromising the service delivery system.

CURTAILMENT/TRANSFORMATION PLAN SUMMARY

Proposed Change	Positions
Additional Service Area 8 Full Service Partnerships	11
Older Adult Field-Capable Teams	5
Reassignment of Existing Staff to Service Area Navigator Teams	4
Reassignment of Employees on Extended/Medical Leave	8
Reassignment of Dual Diagnosis Coordinators	2
Training for Primary Care Providers	N/A
Client-Run Centers	N/A
Workforce Development and Training	N/A
TOTAL	**30**

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