THE LOS ANGELES COUNTY MENTAL HEALTH SYSTEM'S COMMUNITY SERVICES AND SUPPORTS PLAN

A Detailed Summary of the Plan Submitted by Los Angeles County to the California Department of Mental Health in Accordance with the Mental Health Services Act

October 2005

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EXECUTIVE SUMMARY

In November 2004 California voters passed Proposition 63, the Mental Health Services Act. The Mental Health Services Act (MHSA) gives money to counties to help people and families who have mental health needs. To access these funds, counties develop 5 different substantive plans. The first plan is called the Community Services and Supports (CSS) plan.

This document summarizes Los Angeles County's Community Services and Supports plan.

The State Department of Mental Health requires that a county's Community Services and Supports plan focus on children and families, transition age youth, adults, and older adults who have the most severe and persistent mental illnesses or serious emotional disturbances, including those who are at risk of homelessness, jail, or being put or kept in other institutions because of their mental illness. The plan also must provide help to ethnic and racial communities who have difficulty getting the help they need for themselves or their families when they have serious mental health issues.

Since December 2004, thousands of people across Los Angeles County have participated in a fast-paced planning process to develop our first Community Services and Supports Plan. Participants included people who are receiving services, family members, community leaders, community service providers, staff from the Los Angeles County Mental Health Department, staff from other County Departments, and many others. People of all ages have participated in this planning process, including youth 13 years and older and people well over 70.

We have had people from many ethnic and racial communities participate, including members of African American, Armenian, American Indian, Cambodian, Chinese, Hispanic, Korean, Latino, Persian, Russian, Tongan, Western European, and many other racial and ethnic communities.

Some brief numbers will illustrate the scope of this planning process:

- Between December 2004 and March 2005, over 2000 people helped conduct a needs and strengths assessment of the LA County mental health system. This process generated 930 pages of analysis and draft recommendations.
- Between March and September 2005, we conducted 355 workgroup, delegates, and community engagement meetings involving over 11,000 participants, including 268 community engagement and training meetings and 87 countywide workgroup and delegates meetings. Over 120 of the community engagement meetings were conducted in one or more of 13 languages other than English.
- Between June and September 2005 we conducted 17 delegates meetings, some lasting a half-day, many for a full day. Average participation in these meetings has been over 200 people.

- The public hearing conducted on September 20, 2005 drew over 400 people, including over 150 people who receive services and/or who are family members of people with mental health issues.

We have pursued this expansive planning process because of the significant opportunity presented by this plan for Los Angeles County. In the first three years of this effort, the State Department of Mental Health currently estimates that approximately $280 million will come to Los Angeles County to fund our Community Services and Supports Plan, including:

- **$89, 792,800 in FY 2005-06** ($44,896,400 in on-going funds and $44,896,400 in projected one-time funds);
- **$90,690,728 in FY 2006-07;** and
- **$96,078,296 in FY 2007-08.**

The Community Services and Supports Plan is intended to provide services to people in our communities who are most severely challenged by mental health issues, including adults and older adults with severe and persistent mental illnesses, and children and youth suffering from severe emotional disturbances. In this first plan, we have identified a number of priority groups to receive services, including but not limited to:

- **Children (0 to 15)** with severe emotional disturbances and their families **who:**
  - Have been or are at risk of being removed from their homes by the County;
  - Are in families affected by substance abuse issues;
  - Are experiencing extreme behaviors at school; or
  - Are involved with Probation.

- **Transition Age Youth (16-25)** suffering from severe mental health issues, **who are**:
  - Struggling with substance abuse disorders;
  - Homeless or at-risk or becoming homeless;
  - Aging out of the children's mental health, child welfare or juvenile justice system;
  - Leaving long-term institutional care; or
  - Experiencing their first psychotic break.

- **Adults (26-59)** who have severe and persistent mental illness and **who are**:
  - Suffering from substance abuse or other co-occurring disorders, and/or who have suffered trauma;
  - Are homeless;
  - Are in jail;
  - Are frequent users of hospitals and emergency rooms;
  - Are cycling through different institutional and involuntary settings; or
  - Are being cared for by families outside of any institutional setting.

- **Older Adults (60 years+)** who have severe and persistent mental illness and **who are:**
  - Not currently being served and have reduced functioning
  - Homeless or at risk of being homeless
  - Are institutionalized, or at risk of being institutionalized
  - Who are in nursing homes, or receiving hospital or emergency room services.

The guidelines issued by the California Department of Mental Health stipulated a range of services that could be funded through the CSS Plan. In accordance with these guidelines, the Los Angeles County Community Services and Supports Plan proposes to fund the following services:

- Full Service Partnerships in which people create their own plans for recovery with support from professionals and peers, and receive a wide array of services and 24/7 support to make their plan a reality;
- Peer support, peer counseling, and peer mentoring services;
- Housing and residential services, including temporary, supportive, and permanent housing;
- Counseling, assessment, and other traditional mental health services;
- A wide array of alternative crisis services to help people stay out of emergency rooms or other institutional and involuntary settings; and
- Bridging and support services to help people find the supports they need in their communities.

From January 2006, the date we currently expect to begin receiving CSS funds following the State's review of our plan, through June 2008, the timeframe for this first CSS plan, we estimate that these services will reach:

- **9,550** children and their families;
- **11,431** transition age youth and their families;
- **24,180** adults; and
- **7,296** older adults.

Additionally, we project that:

- **59,323** adults, transition age youth and their families, older adults, and children and their families will receive alternative crisis services;
- **18,710** children and their families, transition age youth and their families, adults, and older adults will receive help finding the community based supports and services they need; and
- **45,000** children and their families, transition age youth and their families, adults, and older adults will learn more about mental health issues, the mental health services act, and how to get involved. [1]

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[1] See Exhibit 6 for the calculations upon which these summary estimates are based. Note that these are not unduplicated counts. That is, we expect that some people who receive Alternative Crisis Services, for example, will also receive Full Service Partnership Services and services through our Systems Development investments.

In addition to the services provided with on-going CSS funds, this plan also includes allocations for the use of $44,896,400 in projected one-time funds, including projected allocations for:

- A one-time investment to capitalize a housing trust fund that will provide a source of on-going funding for supportive housing for people with serious mental health needs;
- An investment in a short-term workforce training and development initiative that will help prepare current and future staff within the County mental health system to provide services and supports with a commitment to recovery, and from a place of cultural awareness and competency;
- A one-time investment in needed infrastructure to support the implementation of the CSS plan;
- A one-time investment in an aggressive outreach and engagement campaign to help more people become aware of how to engage in the Mental Health Services Act planning process in Los Angeles County, and to help us begin to identify the needs of hard to reach populations within the County; and
- An investment in a Prudent Reserve Fund as recommended by the California Department of Mental Health to help Los Angeles County weather year-to-year fluctuations in funding for the MHSA.

Several commitments permeate every aspect of the Los Angeles County CSS plan, including commitments to:

- Promote recovery for all who struggle with mental health issues;
- Achieve positive outcomes for all who receive mental health services;
- Deliver services in culturally appropriate ways, honoring the difference within communities;
- Insure that services are delivered in ways that address disparities in access to services, particularly disparities affecting ethnic and cultural communities.

We are building systems to insure that we are held accountable to these commitments over time as we move toward the implementation of the Community Services and Supports Plan for Los Angeles County.

THE LOS ANGELES COUNTY MENTAL HEALTH SYSTEM'S COMMUNITY SERVICES AND SUPPORTS PLAN:

A DETAILED SUMMARY

Introduction

In November 2004 California voters passed Proposition 63, the Mental Health Services Act. The Mental Health Services Act (MHSA) gives money to counties to help people and families who have mental health needs.

To access these funds, counties have to develop 5 different substantive plans (in addition to a plan to plan). The first substantive plan is called the Community Services and Supports (CSS) plan.

This document summarizes Los Angeles County's first Community Services and Supports Plan, submitted to the State Department of Mental Health for in October 2005.

The State Department of Mental Health requires that a county's Community Services and Supports plan focus on children and families, transition age youth, adults, and older adults who have the most severe and persistent mental illnesses or serious emotional disturbances, including those who are at risk of homelessness, jail, or being put or kept in other institutions because of their mental illness. The plan also must provide help to ethnic and racial communities who have difficulty getting the help they need for themselves or their families when they have serious mental health issues.

This summary includes the following sections:

- Section 1 briefly summarizes the public planning process that generated the Community Services and Supports Plan for Los Angeles County;
- Section 2 outlines the overarching themes addressed by the plan;
- Section 3 details the kinds of funding and programs the plan must incorporate according the guidelines issued by the California Department of Mental Health;
- Section 4 details the budget amounts available for each of the three fiscal years; and
- Section 5 summarizes the recommendations for each age group, the cross-cutting recommendations; and the one-time funding recommendations.

Section 1: The Community Planning Process

Since December 2004, thousands of people across Los Angeles County have participated in a fast-paced planning process to develop the first draft of a Community Services and Supports Plan.

Participants included people who are receiving services, family members, community leaders, community service providers, staff from the Los Angeles County Mental Health Department, staff from other County Departments, and many others. People of all ages have participated in this planning process, including youth 13 years and older and people well over 70. We have had people from many ethnic and racial communities participate, including members of African American, Armenian, American Indian, Cambodian, Chinese, Hispanic, Korean, Latino, Persian, Russian, Tongan, Western European, and many other racial and ethnic communities.

The Los Angeles County planning process for the Community Services and Support (CSS) Plan is continuing to unfold through several different structures. Sixty-three delegates, chosen from over 40 different stakeholder groups, have been making all formal decisions during this process. People who receive services and family members, including caregivers of young children, are well-represented as delegates and alternates.

While stakeholder groups formally choose the delegates and alternates who participate in the decision-making process, participation in all other structures is open: anyone who wants to participate can. The work of the delegates is supported by a variety of other work structures, including five countywide workgroups, myriad ad hoc workgroups, and the Service Area Advisory Councils. The Board of Supervisors divided Los Angeles County into eight service areas to facilitate planning within and among County departments. Each Service Area has a Mental Health Service Area Advisory Council that includes people who receive mental health services, family members, mental health service providers, and County Department representatives. Consumers, family members, and advocates actively participate in the work of the countywide workgroups, the ad hoc workgroups, and the Service Area Advisory Councils.

We have been offering modest stipends and transportation vouchers to participants, and investing substantial resources in oral and written translation services to facilitate the participation of people who receive services and families.

The planning process has proceeded through three stages to date:

Phase One: We organized an expansive community process that began in December, 2004 and concluded in March, 2005. This process produced 930 pages of assessment and analysis of the current system and a broad array of preliminary recommendations about how to improve it. Over 30 ad hoc countywide groups formed and participated; in addition, each of the eight Service Area Advisory Councils organized three or more sub-groups to participate in this process as well. Beyond this assessment work, this phase also produced multiple trainings for stakeholder and other groups in the fundamentals of the Mental Health Services Act and how the planning process would unfold in Los Angeles County.

Phase Two: Five countywide workgroups formed to begin work specifically focused on the CSS Plan. The five workgroups included:

- Children 0-15;
- Transition Aged Youth 16-25;
- Adults 26-59;
- Older Adults 60 and older; and
- Under-represented (and Inappropriately Served) Ethnic Populations.

These groups met intensively in full-group and ad hoc workgroup sessions between late April and mid-June, 2005 to draft a series of recommendations for their age group or area of focus for consideration and revision by the delegates. Each workgroup had a participant list of well over 100 people, and included substantial representation from people who receive services, family members, advocates, community-based providers, members of the Service Area Advisory Councils, various Departments, and other groups.

This phase of work continued the trainings on how to participate in the planning process and was delivered in multiple languages to groups across the County. It also included trainings in the recovery model and in various dimensions of Full Service Partnerships as well as systems development.

Phase Three: Beginning in mid-June sixty-three delegates from more than forty Stakeholder groups began meeting in half-day and full-day sessions to review the recommendations from the five countywide workgroups. On average, more than 200 people attended each of the 17 delegate meetings that occurred between June and September 2005. Dozens of ad hoc workgroup sessions also occurred during this period to address issues that arose during the delegates' deliberations.

The delegates' meetings had two fundamental foci: first, to educate the delegates and others about the various recommendations from the Countywide workgroups and about the evolving State guidelines; and second, to engage the delegates in a consensus building process to develop the first draft of the CSS Plan.

We published the draft of our CSS Plan on August 9, 2005, reflecting the consensus achieved among the delegates and stakeholder groups on the overarching budget, and the priority programs and strategies for the first three years of the CSS Plan. Between mid-July, after delegates had reached agreement on the framework for the plan, and September 9, the last day of the thirty-day comment period, we conducted over 200 community engagement sessions involving more than 5000 people. These meetings were organized and supported by community members, people receiving services, family members, DMH staff, community based providers and many others. These sessions:

- Occurred across all 8 Service Areas.
- Engaged people across all four age groups.
- Engaged multiple special populations, including people who are currently homeless, older adults who are homebound, people who are deaf or hearing impaired, parent groups, faith-based groups, probation officers, HIV clinic

patients, social workers, people who are gay, lesbian, or transgender, people in the jails and other institutional settings, and many others.
- Included 127 sessions conducted in 13 different languages other than English, including 58 sessions in Spanish only, 19 sessions in Spanish and English, 9 in Korean, 8 in Armenian, 6 in Japanese, 5 in Thai, 4 in Russian, 4 in Tagalog, 3 in mixed language, 2 in Cambodian, 2 in Cantonese, 2 in Farsi, 1 in Mandarin, 1 in American Sign Language, 1 in Hindi, 1 in Urdu, and 1 in Vietnamese.

All told, since March 2005 we have conducted almost 90 working sessions on various aspects of the plan, including delegates meetings, countywide workgroup meetings, and ad hoc workgroup meetings. The total number of participants in all sessions for which we have documentation since March 2005, including the working sessions, the community engagement and training sessions analyzed above, and other specialized training and engagement sessions, is over 11,000.

Section 2: Overarching themes

The State has mandated, and the delegates to the Los Angeles County planning process have adopted, a number of overarching commitments and themes to guide all of the efforts under the Community Services and Supports (CSS) plan.

A Commitment to Outcomes

First, this plan must demonstrate progress over time to making concrete, measurable improvements in the lives of the people and families who receive services through the CSS plan. In the language of the MHSA, this is called making a commitment to outcomes. Specifically, the State has outlined seven related outcomes that each County will be expected to positively impact for the people and families who receive services under the Community Services and Supports Plan. These outcomes include:

- Meaningful use of time and capabilities, including things such as employment, vocational training, education, and social and community activities;
- Safe and adequate housing, including safe living environments with family for children and youth; reduction in homelessness;
- A network of supportive relationships;
- Timely access to needed help, including times of crisis;
- Reduction in incarceration in jails and juvenile halls; and
- Reduction in involuntary services, reduction in institutionalization, and reduction in out-of-home placements.

In addition to these six outcomes, the delegates to Los Angeles County's planning process have adopted one additional outcome:

- Maintaining or improving physical health as it relates to the achievement of the other outcomes.

These outcomes provided the starting place for delegates' work constructing plans for the four age groups: children, transition age youth, adults, and older adults. In some cases, delegates developed more nuanced statements of the outcomes associated with each age group. (See the discussion of Full Service Partnerships below.) Moreover, age-appropriate indicators will have to be developed for each outcome. For example, indicators for the outcome *meaningful use of time and capabilities* will clearly vary significantly by age group.

A Commitment to Recovery and Wellness

A second major focus for this effort in Los Angeles County, and required by the State guidelines, is a commitment to recovery and wellness. As a starting place for this commitment, we have identified five cornerstones to a commitment to recovery. In everything we do, we should reflect a commitment:

- To the conviction that *recovery is possible*;
- To encourage individuals, families and communities to share responsibility to support one another;
- To provide education about mental illnesses and mental health issues and how they affect individuals and families;
- To teach and promote self-advocacy; and
- To provide meaningful and appropriate support to individuals and families at every step along the pathway to recovery and wellness.

The State's language about recovery and wellness includes the concept of resiliency as well:

> *Recovery* refers to the process in which people who are diagnosed with a mental illness are able to live, work, learn, and participate fully in their communities. For some individuals, recovery means recovering certain aspects of their lives and the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or elimination of symptoms. Focusing on recovery in service planning encourages and supports hope.
>
> *Resilience* refers to the personal qualities of optimism and hope, and the personal traits of good problem solving skills that lead individuals to live, work and learn with a sense of mastery and competence. Research has shown that resilience is fostered by positive experiences in childhood at home, in school and in the community. When children encounter negative experiences at home, at school and in the community, mental health treatments, which teach good problem solving skills, optimism, and hope can build and enhance resilience in children . . . (Mental Health Services Act Community Services and Supports: Three Year Program and Expenditure Plan Requirements, August 1, 2005, pp. 5-6. From this point forward, this document will be referred to as the State CSS Guidelines.)

The delegates to the planning process in Los Angeles County understand that informal and peer-provided social supports are as essential for sustaining long-term recovery and wellness as are services and supports provided by professionally trained service providers, and that our efforts must reflect a resolute commitment to both.

The State has reinforced this commitment in its August 1 guidelines, making clear its expectation that beyond the specific outcome measures for individuals and families, it expects that a number of system improvements will develop as a result of County efforts through the CSS and other Mental Health Services Act plans, including:

- Increases in the level of participation and involvement of clients and families in all aspects of the public mental health system;
- Increases in client and family operated services; . . . [and]
- Increases in the array of community service options for individuals diagnosed with serious mental illness, and children and youth diagnosed with serious emotional disorders and their families, that will allow them to avoid unnecessary institutionalization and out-of- home placements. (State CSS Guidelines, p. 3)

A Commitment to Address Disparities in Access to Services

A third commitment embraced by the Los Angeles County planning process, and specifically required by the State, requires efforts funded by the CSS plan to address disparities in access to services by ethnic and racial groups, and by geography. The State guidelines state that County efforts must include:

> . . . Outreach to and expansion of services to client populations in order to eliminate ethnic disparities in accessibility, availability and appropriateness of mental health services and to more adequately reflect mental health prevalence estimates . . . (State CSS Guidelines, p. 3)

One of the ways the Los Angeles County planning process sought to insure this commitment would be a substantial dimension of any CSS plan submitted by the State was to create a specific Countywide workgroup focused on the needs of Under-represented (and Inappropriately Served) Ethnic Populations. This group developed a series of recommendations for the immediate CSS plan and the long-term transformation efforts in LA County, including recommendations about how funding should be allocated within the first CSS plan. These recommendations are detailed in the discussion of Full Service Partnerships below.

The State has made clear, and delegates to the LA County planning process have agreed, that a commitment to address disparities in access to services must include a commitment to building a culturally competent system, a system that respects and

builds upon the strengths and capacities of different communities. Again, from the August 1 guidelines:

> . . . Cultural competence includes language competence and views cultural and language competent programs and services as methods for elimination of racial and ethnic mental health disparities. There is a clear focus on improved quality and effectiveness of services. Service providers understand and utilize the strengths of culture in service delivery. Culturally competent programs and services are viewed as a way to enhance the ability of the whole system to incorporate the languages and cultures of its clients into the services that provide the most effective outcomes and create cost effective programs. (State CSS Guidelines, p. 6)

Although the State has not yet issued guidelines for the Workforce Training and Development Plan that will be required under the Mental Health Services Act, delegates have recommended using one-time funds to support a short-term workforce training and development initiative to help prepare current and future staff to provide services and supports with a commitment to recovery, and from a place of cultural awareness and competency.

A Commitment to Age Appropriate Strategies

Los Angeles County delegates have embraced a commitment to age-appropriate strategies, beginning with the State's age groups of Children 0-15, Transition Age Youth 16-25, Adults 26-59, and Older Adults 60 and older. Delegates also recognize that differences often exist within these somewhat arbitrary age groupings—e.g., the needs of older adults who have just turned 60 may be profoundly different than older adults who are over 80; the needs of transition age youth who are 16 are often quite different than youth who are in their mid-twenties. Delegates sought to develop strategies that accounted for different needs within age groups, and have made a commitment to refine this plan over time to develop even more nuanced approaches to such sub-age group issues.

A Commitment to Address Substance Abuse and Other Co-Occurring Disorders

Delegates have recognized that an overwhelming percentage of people who suffer from severe and persistent mental illness or severe emotional disturbances also suffer from complications due to co-occurring disorders, including in particular substance abuse issues. Each of the plans associated with the four age groups has clearly articulated and embraced a commitment to build a system that seamlessly and effectively addresses co-occurring disorders that often significantly exacerbate the effects of mental illness.

A Commitment to Community Collaboration and Integrated Services

Beyond these specific commitments, the State also expects, and Los Angeles County delegates have embraced, commitments to community collaboration and integrated services. The multiple strategies recommended for funding in this plan all require significant collaboration between the Los Angeles County Department of Mental Health and multiple other partners, including self-help and peer advocacy groups, family groups, community-based and faith-based organizations, community-based providers, other County Departments, law enforcement agencies, and myriad others.

Section 3: Distinguishing two kinds of funding and the different investments supported by each

The first CSS plan covers three fiscal years: July 2005 through June 2006, July 2006 through June 2007, and July 2007 through June 2008.

Given the complexity of the planning process required to complete the first draft of the CSS plan, the earliest that Los Angeles and other counties can expect to receive funding from the State is January 2006, half-way through the first fiscal year. Since the State is administering the CSS plans on a fiscal year basis, this means that Counties will not have plans for at least the first half of the first fiscal year (or longer if they take longer to submit their plans to the State).

To address this timing anomaly in the first year, the State is allowing Counties to treat the un-used portion of their first year allocations as one-time funds. Los Angeles County's first year allocation for the CSS is approximately $90 million. Assuming we submit our plan to the State by early October 2005 and the State approves the plan in time for funding to be available by January 2006, Los Angeles County would potentially have access to half of its first year allocation, or $45 million, as one-time funds.

So: the first funding distinction is that there are *on-going funds* and *one-time funds*. The State further stipulates allowable uses for both kinds of funding.

Allowable uses for on-going funds

For *on-going* funds, there are three kinds of allowable investments: full-service partnerships, general system development initiatives, and outreach and engagement funding.

Full-service partnerships have several defining characteristics, including providing a wide array of services and supports, guided by a commitment by providers to do *whatever it takes,* to help individuals within defined focal populations (discussed more fully below under each age group) make progress on their particular paths to recovery and wellness. More descriptively:

- Discrete **individuals who meet certain population criteria** (called focal population criteria) enroll in a Full Service Partnership program.
- Each enrolled individual (and their family where appropriate) participates in the development of a **plan** that is **focused on recovery and wellness.**
- The plan can include **traditional mental health services as well as a wide array of other services**—e.g., housing services, employment services, peer support services, substance abuse treatment services, recreational or other therapeutic services—consistent with a commitment to support and do **"whatever it takes"** to help the individual progress toward recovery and wellness. Programs can provide the range of services required by clients directly, or can link to other organizations and providers to insure that the services agreed to in the plan are available to the client and the family where appropriate.
- Each enrolled individual has a **single point of responsibility for the provision of services and supports.** In most programs this will be through a **team**, each member of which has a sufficient trusting relationship with the individual receiving services that the individual feels comfortable calling team members when they need help.
- Team members must have low enough caseloads to insure **24/7 availability.** In many programs this is estimated to be no more than 15 clients to 1 staff member.
- Programs will report **quarterly on outcomes** achieved for the individuals enrolled. (State CSS Guidelines, p. 22-23)

System development funds are funds to improve programs, services and supports for the populations to be served by full service partnerships, and for other populations consistent with the State-mandated populations for the Community Services and Supports plan. As a general rule, Counties may use system development funds to improve programs, services and supports for all clients and families and to transform their programs and services in ways consistent with the values and aims of the MHSA. (State CSS Guidelines, p. 8)

Counties may also use on-going funds to support *outreach and engagement efforts* targeting those populations that currently receive little or no service. The August 1 guidelines specifically restrict the use of these funds to those activities designed to reach un-served populations. Individuals who may have had extremely brief and/or only crisis oriented contact with and/or service from the mental health system are considered un-served for the purposes of this funding. (State CSS Guidelines, p. 8)

Of these three allowable uses for on-going funds—full service partnerships, general system development investments, and outreach and engagement—State guidelines specify that a majority of a County's CSS investments must be devoted to full service partnerships.

Allowable uses for one-time funds

Under the guidelines issued by the State for one-time funds, Counties can develop plans for these funds that include:
- Extensions of Community Program Planning Funding;
- System Improvement Funding;
- Other One-Time Community Services and Supports Funding; and
- Funding for a Prudent Reserve.

With certain exceptions—e.g., funding for the Prudent Reserve—all one time funds must be expended by June 30, 2006. (DMH Letter No. 05-06, September 2, 2005.)

Section 4: Projected three year budget amounts

The State has projected that Los Angeles County will receive the following allocations for its Community Services and Supports plan over the next three fiscal years:

- FY 2005-06: **89,792,800**
- FY 2006-07: **90,690,728**
- FY 2007-08: **96,078,296**

We project that we will begin receiving on-going funds in January 2006, half-way through FY 2005-06. Therefore, we project that we will have $44,896,400 available in on-going funds for the second half of FY 2005-06, and an equivalent amount in one-time funds. The tables in Exhibit 2 detail the current projected budgets for each age group and the plan as a whole.

Section 5: Summary of the funding recommendations for the first three-year CSS plan

What follows is a summary of the consensus recommendations delegates have approved for the first three-year Community Services and Supports Plan.

This section proceeds through the following structure:
- A summary of the Full-Service Partnership recommendations for each age group;
- A summary of the Systems Development recommendations for each age group;
- A summary of the Cross-Cutting recommendations that address all or multiple age-groups;
- A summary of the One-time Funding recommendations.

FULL SERVICE PARTNERSHIPS FOR EACH AGE GROUP

The Full Service Partnerships for all age groups will reflect the characteristics described on page 9 above. The differences in design will reflect the different focal populations chosen for each age group, and the particular outcomes sought for the focal populations. The following sections, therefore, first outline the focal populations and priority outcomes delegates identified for each age group. Additionally, each section contains beginning reflections about design criteria for age specific full service partnerships. Delegates will develop more refined criteria for the implementation of full service partnerships in the coming weeks as they begin to focus on design and implementation issues related to the CSS plan.

Following these sections are two additional sections related to Full Service Partnerships: the first estimates the number of people to be served under each age group across the three fiscal years of this first CSS plan; the second summarizes the approach the delegates have endorsed for allocating the Full Service Partnerships by age group, by ethnicity, by Service Area, and by focal population.

Full Service Partnerships for Children 0-15

1. Recommended Target Populations for Children's Full Service Partnerships

In the August 1, 2005 guidelines the State Department of Mental Health recommends several groups of children aged 0-18 as candidates for target populations. These groups include children and youth between the ages of 0 and 18,[1] or Special Education students through the end of the school year in which they turn 22 and their families, who have serious emotional disorders and who are not currently being served. This population generally consists of:

- Youth and their families who are uninsured, under-insured and/or youth who are not eligible for Medi-Cal because they are detained in the juvenile justice system;
- Homeless youth, youth in foster care placed out-of-county and youth with multiple (more than two) foster care placements;
- Children and youth who are so underserved that they are at risk of homelessness or out-of-home placement. (State CSS Guidelines, p. 21)

Delegates embraced the State's recommended focal populations, though many of the sub-groups specified by the State actually fall within the focal populations identified by

[1] The first draft of the CSS guidelines issued by the State set the age range for children at 0-15. In subsequent versions of the guidelines, including the final guidelines, the State established the age range for children at 0-18, creating an overlap with Transition Age Youth. We have opted to keep the age range for children at 0-15, and to create ad hoc structures for the Children and Transition Age Youth workgroups to work together when they are addressing issues that cross between the two populations.

the Transition Age Youth (TAY) workgroup (see the TAY discussion in the next section). The delegates further defined the recommended focal populations to include children (0 to 15) with severe emotional disorders [SED] and their families, with a priority placed on children with co-occurring disorders, recent hospitalizations, psychotic disorders, or showing symptoms of trauma experiences. In particular we will focus on:

- Pre-natal to 5 year olds who are at high risk of being expelled from pre-school, involved with or at high risk of being detained by the Department of Children and Family Services (DCFS); or children of parents or caregivers who have SED or severe and persistent mental illness, or have a co-occurring substance abuse disorder;

- Children who have been removed from their homes or who are at high risk of being removed from their home by DCFS, and who are in transition to less restrictive placements;

- Children who are experiencing the following at school:
  - Expulsion or suspension, or high risk of either;
  - Violent behaviors;
  - Drug possession or use;
  - Suicidal and/or homicidal ideation; and/or
  - Truancy; and

- Youth involved with the Probation Department who are being treated with psychotropic medications and who are transitioning back into less structured home and community settings.[1]

2. Recommended Outcomes

Delegates have embraced the outcomes for children and their families as specified by the State's August 1, 2005 guidelines, including:

- Meaningful use of time and capabilities, including employment, vocational training, education, and social and community activities;
- Safe and adequate housing, including safe living environments with family for children and youth; reduction in homelessness;
- A network of supportive relationships;
- Timely access to needed help, including during times of crisis;
- Reduction in incarceration in jails and juvenile halls; and
- Reduction in involuntary services, reduction in institutionalization, and reduction in out-of-home placements.

[1] Delegates also identified transition age youth in Probation Camps as a priority population. Full Service Partnership models will be encouraged that serve both populations seamlessly.

Delegates also embraced the additional outcome of maintaining or improving physical health, as it relates to the achievement of the other outcomes, for children and their families.

3. Beginning Design Reflections for Full Service Partnerships for Children

Delegates embraced the definition of Full Service Partnerships as outlined above. Delegates also embraced a range of other criteria for Full Service Partnerships for this age group, including:

- Services provided in the home, school, and community;
- Strength-based assessments;
- Services provided to family members when essential for the achievement of outcomes for the child;
- Benefit establishment services;
- Mental health treatment for parents of SED children who may not meet the target population definition in the adult system;
- Evidence based treatment practices; and
- Support for parent and caregiver advocacy.

Full Service Partnerships for Transition Age Youth 16-25

1. Recommended Target Populations for Full Service Partnerships

On August 1, 2005, State Department of Mental Health guidelines recommended several groups of Transition Age Youth 16-25 as candidates for target populations. These groups include transition age youth between the ages of 16 and 25, who are currently unserved or underserved who have serious emotional disorders and who are:

- Homeless or at imminent risk of being homeless;
- Youth who are aging out of the child and youth mental health, child welfare and/or juvenile justice systems;
- Youth involved in the criminal justice system or at risk of involuntary hospitalization or institutionalization; and
- Transition age youth who have experienced a first episode of major mental illness.

The delegates have embraced the State's recommended focal populations, and further refined them in the following manner. The delegates intend to make a long-term commitment to all transition age youth 16-25 who have severe emotional disturbances (SED) or Severe Mental Illnesses (SMI) that result in significant functional impairment, or who demonstrate significant social, emotional, educational and/or occupational impairments who could meet the criteria for an SED and/or SMI diagnosis, including those youth with dual diagnoses or co-occurring disorders, including substance abuse disorders and others.

During the first three years of the CSS Plan, however, focus will be on those youth who are unserved, underserved or inappropriately served, including those who are homeless, or at risk of homelessness, and/or youth aging out of the children's mental health, child welfare, and juvenile justice systems.

In particular, we will give priority to youth who:

- Have been in or are leaving long term institutional settings—e.g., level 14 group homes—including those youth who, though diagnostically qualified for level 14 group homes, were living in other settings;
- Have been in hospitals, Institutes for Mental Disease (IMDs), Community Treatment Facilities, jails, and/or Probation Camps; and
- Youth who have experienced their first psychotic break.

2. Recommended Outcomes

Delegates have embraced the State's outcomes for transition age youth, including:

- Meaningful use of time and capabilities, including employment, vocational training, education, and social and community activities;
- Safe and adequate housing, including safe living environments with family for children and youth; reduction in homelessness;
- A network of supportive relationships;
- Timely access to needed help, including during times of crisis;
- Reduction in incarceration in jails and juvenile halls; and
- Reduction in involuntary services, reduction in institutionalization, and reduction in out-of-home placements.

Delegates also embraced three additional outcomes for transition age youth:

- Maintaining or improving physical health, as it relates to the achievement of the other outcomes;
- Reduction in early pregnancy; and
- Completion of high school diploma or a GED.

A note about age appropriateness and transition age youth: Delegates fully appreciate the unique developmental challenges faced by this group of young people, above and beyond whatever mental health challenges they face. Our use of different phrases throughout this report, youth, young people, young adults, is intended to suggest some of these age-related developmental challenges. All of the recommendations in this report, both within Full Service Partnerships and system development investments, presume a commitment to ultimately helping transition age youth who are receiving services to achieve the highest level of self-sufficiency possible. What this means in practice will vary depending on many factors including age, culture, and ethnicity.

For many youth 16-18 or even older, helping them establish or re-establish appropriate relationships with family members or other adult caregiver is crucial to helping them progress toward self-sufficiency. Many young people, however, even some in younger ages, have already begun to transition to independence, and establishing relationships with family members or other adults must reflect this reality.

The complexity of these dynamics reflects the essential requirement to tailor services and supports to the particular needs of the individual. As a general principle, however, we understand all of the recommendations made here to reflect both a commitment to provide services to young people in the context of their relationships with their families and communities, and a commitment to support the maximum levels of self-sufficiency possible.

3. Beginning Design Reflections for Full Service Partnerships for TAY

Delegates embraced the definition of Full Service Partnerships for transition age youth as outlined above.

In addition, delegates agreed that one of the most essential elements for success of Full Service Partnerships is a strong commitment to meet the housing needs of enrolled youth and young adults. Delegates believe that such a commitment is crucial for ensuring that youth and young adults enrolled in Full Service Partnerships have a stable environment in which to work toward recovery and wellness.

Included within the initial cost estimates for Full Service Partnerships for transition age youth are the cost estimates for a range of housing options to be made available to youth and young adults enrolled in these programs including:

- Hotel vouchers for emergency housing;
- Rental subsidies and vouchers;
- Access to housing, and housing with supportive services, specifically designated and designed for transition age youth with SED or SMI; and
- Other appropriate housing assistance.

Full Service Partnerships for Adults 26-59

1. Recommended Target Populations for Full Service Partnerships for Adults

The State Department of Mental Health August 1 guidelines recommended several groups of adults with serious mental illness as potential focal populations, including adults with a co-occurring substance abuse disorder and/or health condition who are either not currently served and meet one or more of the following criteria:

- Homeless;
- At risk of homelessness, such as youth aging out of foster care or persons coming out of jail;

- Involved in the criminal justice system, including adults with child protection issues; or
- Frequent users of hospital and emergency room services;
- Or who are so underserved that they are at risk of:
  - Homelessness, such as persons living in institutions or nursing homes;
  - Criminal justice involvement;
  - Institutionalization; or
  - Transition age older adults (often between the ages of 55 and 59) who are aging out of the adult mental health system and at risk of any of the above conditions or situational characteristics are also included. (State CSS Guidelines, p. 21)

The delegates embraced the State's recommended focal populations, and further refined them as follows. We will focus our initial CSS Full Service Partnerships for adults on those people with serious mental illness, including people who have co-occurring disorders and/or have suffered severe trauma, who are so unserved or underserved as to be:

- Homeless;
- In jail;
- Frequent users of hospitals or emergency rooms;
- In other institutional settings (including State Hospitals, IMDs, Urgent Care Centers, various residential treatment and other facilities); or
- With family members or in other settings and, because of their mental illness, are at imminent risk of homelessness, jail, and/or institutionalization.

2. Recommended Outcomes

Delegates have embraced the outcomes for adults as specified by the State, including:

- Meaningful use of time and capabilities, including employment, vocational training, education, and social and community activities;
- Safe and adequate housing, including safe living environments with family for children and youth; reduction in homelessness;
- A network of supportive relationships;
- Timely access to needed help, including times of crisis;
- Reduction in incarceration in jails and juvenile halls; and
- Reduction in involuntary services, institutionalization, and/or out-of-home placements.

Delegates also embraced the additional outcome of maintaining or improving physical health as it relates to the achievement of the other outcomes for adults.

Full Service Partnerships for Older Adults 60+

1. Recommended Target Populations for Full Service Partnerships for Older Adults

The August 1, 2005 guidelines issued by the State Department of Mental Health recommended several groups of Older Adults 60 and older as candidates for target populations. These groups include older adults 60 years and older with serious mental illness, including older adults with co-occurring substance abuse disorders and/or other health conditions, who are not currently being served and:

- Have a reduction in personal or community functioning;
- Are homeless;
- At risk of homelessness, institutionalization, nursing home care, hospitalization and emergency room services; or
- Older adults who are so underserved that they are at risk of any of the above.

Transition age older adults may be included under the older adult population when appropriate.

The delegates embraced the State's recommended focal populations, and further refined them as follows. We will focus our initial CSS Full Service Partnerships for older adults 60 years and older with serious mental illness, including:

- Individuals with co-occurring disorders that include substance abuse disorders, developmental disorders, medical disorders and cognitive disorders with a primary diagnosis of mental illness;
- Those at imminent risk for placement in Skilled Nursing Facility (SNF) or released from SNF, possibly conserved;
- Adult Protective Service-referred clients with a history of self-neglect or abuse and who are typically isolated;
- Clients at high risk of going to jail or released from jails;
- Intensive service recipients (clients with 6 or more hospitalizations in the past 12 months);
- Clients currently in the system who are aging up in the system, e.g., consumers who have suffered from severe mental disorders in earlier years who are now becoming senior citizens, perhaps currently in adult "ACT-like programs;" and
- Clients at high risk for suicide

2. Recommended Outcomes

Delegates have embraced the outcomes for older adults as specified by the State, including:

- Meaningful use of time and capabilities, including employment, vocational training, education, and social and community activities;
- Safe and adequate housing, including safe living environments with family for children and youth; reduction in homelessness;
- A network of supportive relationships;
- Timely access to needed help, including times of crisis;

- Reduction in incarceration in jails and juvenile halls; and
- Reduction in involuntary services, reduction in institutionalization, and reduction in out-of-home placements.

Delegates modified the wording of these outcomes to more appropriately apply to older adults. The refined list of outcomes includes:

- An affordable, safe and nurturing environment that is, as least restrictive as possible, supporting optimal functioning in a safe living arrangement;
- A meaningful way to use one's time, including a sense of community connectedness, and feelings of value and esteem within the community;
- Meaningful and supportive relationships with others ;
- A full array of culturally sensitive, age appropriate mental health and supportive services, available in all geographic areas;
- Maintaining optimal functional ability and physical, cognitive and mental health; and
- Ability to exercise self-determination.

3. Beginning Design Reflections for Full Service Partnerships for Older Adults

Delegates have developed a preliminary list of potential design criteria for Full Service Partnerships for older adults, including:

- Multidisciplinary staff with training and experience in working with older adults
- Experience with and commitment to delivering in-home services
- Demonstrated experience providing specialized interventions that have been shown to have promise for older adults
- Experience identifying, integrating and addressing the multi-faceted needs of older adult clients in the areas of mental health, substance abuse, health & hygiene, benefits establishment, housing, transportation, and nutrition.
- Demonstrated ability to work collaboratively with primary care providers
- Experience delivering field-based services to older adults in sites such as nursing facilities, senior centers, faith-based organizations or congregate meal programs
- Ability to work with the three focal populations of older adults: those age 60 to 64, 65 to 84 and those over the age of 85
- Commitment to working with the families of older adults, including providing caregiver support groups
- Commitment to a significant period of engagement to establish relationships
- Expertise in recognizing suicidality and conducting periodic assessments of suicidality of at-risk clients
- Demonstrated experience in providing treatment options including psychotherapy in the home
- Available consultation with a gero-pharmacist, occupational therapist and nutritionist and coordination of care with primary care physician
- Ability to provide or arrange transportation that is truly "door through door"

- Demonstrated experience and/or ability to partner with the range of older adult resources including: Caregiver resources, Multi-Service Senior Program, Adult Day Health Care Center, Primary Care Providers, APS, and Public Guardian

Allocation of Full Service Partnerships by Age Group, By Ethnicity, By Service Area, By Focal Population

Conservative estimates calculate the unmet need in Los Angeles County for mental health services for those suffering from severe mental health issues at over 112,000 people (See pp.. 42-55 of the Los Angeles County Community Services and Supports Plan for an analysis of the data that produced this estimate.) When fully staffed and operational, the Full Service Partnerships will support 4,333 people and their families. The relative impact these initial Full Service Partnerships will have, therefore, is small. Our intention, however, is to use these investments to help us learn how to more effectively and efficiently create the broad range of supports that individuals need to accelerate their recovery. Moreover, we are committed to use these new funds to learn how to set and meet targets for different populations so that we can pursue a more ambitious agenda of addressing disparities in access to services in coming years.

We have begun to act on this commitment as follows. We first identified several criteria to help us set preliminary targets for Full Service Partnerships to different ethnic groups by age and by service planning area. These criteria included: poverty by age by ethnicity by service area; the number of uninsured by age by ethnicity by service area; and number of households where English is not the primary language by age by ethnicity by service area.

We quickly discovered that reliable data by age by ethnicity by service planning area only exists for the poverty criterion; the other two criteria can only be analyzed Countywide or by service planning area, but not by age by ethnicity by service area.

The delegates decided to start with the poverty data and do a first calculation of countywide slots by ethnicity. We will then analyze the demographic data for the various focal populations by service area and begin to develop coherent designs for Full Service Partnerships that will stay within the recommended allocations. We will then monitor these targets on a quarterly basis, reporting back to the delegates our progress and identifying where we may need to strengthen our outreach and engagement efforts. Additionally, we will create some specialized slots for dispersed ethnic and special populations—e.g., American Indians—to insure we are creating services for those populations and learning how to improve the larger service system's efforts on their behalf.

One last calculation we have done relative to the allocation of Full Service Partnerships is to set targets for the uninsured in Los Angeles County. We have set ambitious targets for reaching the uninsured in each age group in order to insure that these funds provide support and hope for the most vulnerable citizens with mental health needs in our

community. Specifically, these targets are: 10% for children, 35% for transition age youth, 35% for adults, and 20% for older adults. That is, the expectation is that we will serve at least this percentage of people who will not have access to other payer sources for a year or longer. These targets do not reflect any diminishment of the system's commitment to aggressively pursue and establish benefits for all who are eligible; instead the targets are intended to reflect the intention to reach the most unserved and difficult to serve among the various age groups.

Note that these targets are for actual people served, not for MHSA dollars allocated. This distinction has important implications for the calculations in the next section about numbers to be served. To estimate the total number of people to be served through Full Service Partnerships, we have to distinguish between 3 groups of people:

- Those who have benefits—e.g,. Medi-Cal—on the day they enroll in a Full Service Partnership (Insured);
- Those who do not have benefits on the day they enroll but who will have benefits established at some time during the year (Will be Insured); and
- Those who will not be able to have benefits established for them at any point in the program (Uninsured).

The targets we have set for the uninsured relate to this last group—those who will not be able to have benefits established for them at any point in the program (uninsured). For example, we expect more than 35% of adults who enroll in Full Service Partnerships to begin these programs without any alternative payer source. We project, however, that after our best efforts to establish benefits for all of these adults that at least 35% of them will still be uninsured. Again, the importance of this commitment is to insure that we are designing our outreach and engagement efforts to reach the most vulnerable citizens with mental health needs in our community.

To meet these targets, however, requires that we estimate the amount of funds to be leveraged with MHSA dollars, and to insure that we have sufficient *unencumbered MHSA funds* (funds not used to match alternative payer sources) to be able to provide services to the numbers of people we want to serve who do not have benefits. These funds fall into two categories:

- Funds to provide all services to the *Uninsured*; and
- Funds to provide all services to the *Will be Insured* for the period of time they do not have benefits.

A third category of funds also has to be set aside: funds for those services that will not be reimbursed regardless of who receives them. Full Service Partnerships embody a "whatever it takes" commitment, meaning that every effort is made to provide whatever services a person needs in order to make significant progress toward recovery and wellness. Many of these services, however, will not be reimbursable under Medi-Cal or other benefits programs—e.g., outreach and engagement services, housing services, or employment services. So-called "flexible funds" have to be set aside and not used to leverage other funds in order to insure that sufficient resources are available to pay for these non-reimbursable but essential services.

Calculating the precise amount of funds that have to be withheld from any leveraging projections, and the precise average cost of the non-reimbursable services to be provided, is more art than science at this stage in our development. While we have substantial experience administering AB 2034 programs for adults and Wraparound programs for children, we have very little experience developing and implementing Full Service Partnership programs for the older adult and transition age youth focal populations. Moreover, even within our adult and children focal populations, estimating the amount of dollars required for outreach and engagement efforts, a crucial component of flex funds, and the precise amounts of additional funds that may be required for housing, employment services, and other more expanded non-traditional mental health services that will be essential for achieving the expected outcomes for the most severely and persistently mentally ill people who are the target of Full Service Partnerships in this first plan.

We have attempted to reflect these various uncertainties for now by showing ranges of numbers to be served, and ranges for the estimated average costs per client. Note that for the projected budgets required by the State, we have used the *lower* estimates of numbers to be served for every age group *except* for Older Adults, where we used the higher estimate. We will continue to refine our estimates of these numbers over the next month as we finalize the design criteria for Full Service Partnerships targeting each focal population.

Estimates of numbers to be served through Full Service Partnerships

1. Children 0-15
   a. Total children to be served through Full Service Partnerships
      (1) FY 2005-06: 384-409
      (2) FY 2006-07: 1534-1638
      (3) FY 2007-08: 1534-1638

   b. Estimated average cost per client: $16,500-$17,615

   c. Estimated percentage of children receiving services who will be eligible for alternative payers sources at some time during a full year of service: 90%

   d. Estimated annual amount to be leveraged through Early Periodic Screening, Diagnosis, and Testing (EPSDT) funds when fully operational: $21,607,465 per year

2. Transition Age Youth 16-24
   a. Total TAY to be served through Full Service Partnerships
      (1) FY 2005-06: 207-234
      (2) FY 2006-07: 828-938
      (3) FY 2007-08: 828-938

   b. Estimated average cost per client: $15,520-$17,580

c. Estimated percentage of children receiving services who will be eligible for alternative payers sources at some time during a full year of service: 65%

d. Estimated annual amount to be leveraged through Early Periodic Screening, Diagnosis, and Testing (EPSDT) funds, Medi-Cal funds, and Healthy Families when fully operational: $7,839,128

3. Adults 25-59
   a. Total to be served
      (1) FY 2005-06: 441-664
      (2) FY 2006-07: 1766-2657
      (3) FY 2007-08: 1766-2657
   b. Estimated average cost per client: $15,000-$22,567

   c. Estimated percentage of adults receiving services who will be eligible for alternative payers sources at some time during a full year of service: 65%

   d. Estimated annual amount to be leveraged through Medi-Cal when fully operational: $8,911,440

4. Older Adults 60 +
   a. Total to be served
      (1) FY 2005-06: 31-41
      (2) FY 2006-07: 158-205
      (3) FY 2007-08: 158-205

   b. Estimated average cost per client: $15,000-$19,447

   c. Estimated percentage of older adults receiving services who will be eligible for alternative payers sources at some time during a full year of service: 80%

   d. Estimated annual amount to be leveraged through Medi-Cal when fully operational: $973,844

SYSTEMS DEVELOPMENT INVESTMENTS FOR ALL AGE GROUPS

Systems Development Investments for Children 0-15

System Development investments for children will target SED children and their families including those who are in full service partnerships. The goal is to support a system in which children are served within the context of their families. Service systems will be created and transformed to meet the needs of unserved, under-served, and inappropriately served children and their families.

Recommended systems development investments include:

Family Support Services, including additional services as allowed under the CSS guidelines for parents, caregivers, and/or other family members of children who are enrolled in full service partnerships but who do not themselves meet the criteria established for full service partnerships for their age group. These services would be determined as essential for the achievement of the outcomes of the child or children enrolled in full service partnerships. These services would be prioritized for those parents, caregivers, or other family members without other funding sources, who are not covered under other systems of care, and who do not qualify for collateral services.

Integration of Mental Health and Substance Abuse Treatment Practices: This strategy is essential to support the effective implementation of full service partnerships and includes developing fully integrated co-occurring disorder models of treatment to serve both children who have caregivers with co-occurring disorders and children who themselves have co-occurring disorders.

Family Crisis Services: Respite care for parents and caregivers of children with SED. These services will be provided primarily to families of children who are enrolled in Full Service Partnerships. Respite Care is a support service for families providing constant care for a person with a disability or serious illness. Respite care programs are designed to help relieve families from the stress that results from caring for a disabled child or adult. Available as a service to families in the developmental disabilities system for over 20 years, respite care has proven itself to be the most cost-effective family support system. Families in the same circumstances in the mental health system have done without similar support, suffering in silence. Delegates believe that many tragedies, where families with a seriously mentally ill family member have been torn apart due to the immense stress of caregiving, could have been prevented had respite care been available.

In the year 2000, the California State Legislature included language in the State Budget to establish the Mental Health Respite Care Pilot Project to be administered by county mental health departments. Chapter 93, Part 3.5 language stated that *"respite care provided to families caring for a seriously emotionally disturbed child or seriously mentally ill adult is critical to assist them in keeping their family member in the home and maintaining the stability of the family."*

Currently available only to families in the developmental disabilities system, delegates believe it is important to make respite care available to family members of children and youth, ages 0-15, who meet the eligibility criteria of Full Service Partnerships.

Systems Development Investments for Transition Age Youth 16-25

Delegates embraced 3 overarching purposes to their system development investments for transition age youth:

- Improve ease of entry and access to the system;
- Increase short-term and long-term housing options; and
- Increase quantity and quality of MH services in the juvenile camps.

Extend the operating hours of drop-in centers: Transition age youth with serious mental health issues are often highly transient, and therefore present unique challenges for providing effective services and supports. One of the first conditions for providing services and supports is to establish a trusting relationship with the person to receive services. Delegates are recommending significant resources to extend the operating hours of drop-in centers around the County to include at least some evenings and weekends when they are needed most. Such centers have a proven track record of creating safe environments where transition age youth can begin to develop trusting relationships that can lead to longer term supports and services.

Increase housing options available to Transition Age Youth: Transition age youth with serious mental health issues frequently struggle to find safe emergency housing, and safe permanent housing. Delegates are recommending investments in a network of **Housing Specialists** to help transition age youth get access to a range of housing options, from emergency shelter to permanent housing. These specialists will work with landlords and others who can help provide housing for transition age youth. They will also develop expertise about the available housing subsidies, supports, and services for which particular transition age youth may qualify.

Additionally, delegates are recommending investments in **emergency housing vouchers**, which will help transition age youth living on the street to find some temporary housing from which they can begin to receive services and, with support, develop longer term plans. Delegates are also recommending significant investments in **project based housing subsidies** that will help establish permanent housing units available to transition age youth with serious mental health issues.

Increase mental health services in the Probation Camps: Delegates recommended significant investments to young people in the Probation Camps who may not yet be prepared or able to transition from the camps into full service partnerships. Delegates believe that services in the Probation Camps are critical in assisting this portion of the TAY population with mental health needs to reach their maximum potential rather than continue their involvement in the criminal justice system as adults.

The proposed multi-disciplinary, integrated teams will provide an array of services aimed at successfully transitioning youth out of the Probation settings. Using a recovery approach, which views mental illness as a condition from which an individual can recover and live a healthy and productive life, these teams will be inclusive of parent/peer advocates, clinicians, and Probation staff who will provide a variety of treatment and support services, including: assessments for mental illness, co-occurring substance abuse issues, and medications; ongoing treatment services; peer support; parent support/education; behavior management; discharge planning, including benefits

establishment and transition planning with linkages to Full Service Partnerships (FSPs) in the community and to family, if appropriate.

Systems Development Investments for Adults 26-59

Delegates reached consensus on several priorities for the general system development investments for adults.

Wellness and Client-Run Support Centers to support adults in full service partnerships and other adults with severe and persistent mental illness. Wellness/Client Run Support Centers are designed to offer options to clients who no longer need the intensive services offered by the FSP programs, who may be receiving services from less intensive outpatient programs, and who are ready to take increasing responsibility for their own wellness and recovery.

Ideally the Wellness/Client Run Support Centers will be located in their own buildings centrally located to many other community organizations, rather than as part of an outpatient clinic or FSP program site. Activities at the Centers will include scheduled appointments with the Nurse Practitioner or Psychiatrist for medication or physical health issues (Wellness Centers); participation in small self-help meetings and workshops; research or use of a small computer/resource library; and meetings/ interactions with other staff who work there. In addition, the Centers will need a "welcome area," where anyone entering can find peer support staff available for questions, concerns, or help with scheduling services. The environment is intentionally friendly, welcoming, and "non-institutional" in appearance. Larger workshops, self-help meetings, and planned social events are held at larger venues outside the Wellness/Client Run Support Centers.

The Wellness Centers address both mental and physical health, based on research showing that people with mental health issues also have a high incidence of serious physical health problems, including diabetes, hypertension and obesity, which can be side effects of medications. Wellness Centers offer a variety of support and strategies to its participants, addressing their physical and mental health needs. With the Wellness Recovery Action Plan (WRAP) at the core, there is an enormous emphasis on pro-active behavior, preventative strategies, and self-responsibility. The Wellness Center integrates this with mental and physical health education, self-help meetings, peer support, and medical and psychiatric support, in order to help program participants continue in their recovery and pursue their goals for a healthy life.

In the spirit of developing a community of inclusion, the Wellness/Client Run Support Centers welcome anyone in the community to participate in the variety of self-help, educational, and social/recreational activities they offer. These Centers are committed to increasing the capacity of the community to include all citizens. Community development will be a critical component of the Centers' efforts because of the many benefits created by becoming active in the life of a community. Community development provides opportunities for individuals to develop non-institutional support mechanisms,

reduce stigma, and decrease reliance on mental health and other related systems, all critical elements of success as individuals strengthen their self-reliance. Persons participating in these Centers need not be enrolled in a program and groups will be available to members of the public who would like to participate.

Step-down facilities from IMDs: The IMD Step-down Facilities program provides supportive on-site mental health services and limited operational costs, when necessary, at selected licensed Adult Residential Facilities (ARF), and in some instances, assisted living, congregate housing or other independent living situations affiliated with the ARFs. The program will serve 50 to 100 individuals at any given time, 18 years of age and above, the majority of who are persons ready for discharge from Institutions for Mental Disease (IMD). The program will also accommodate persons being discharged from acute psychiatric inpatient units or intensive residential facilities, or at risk of being placed in these higher levels of care, who are appropriate for this service. The program will target those individuals in higher levels of care who require supportive mental health and supportive services to transition to stable community placement and prepare for more independent community living. Strategies and features of this Systems Development investment are:

- The anticipated length of stay will be two to six months for the ARFs and unlimited for clients in assisted living, congregate housing or other independent living situations.
- The program will have 24/7 capacities for emergencies and specialized programming.
- Staffing for these supportive residential programs will include licensed mental health professionals, mental health workers, certified drug and alcohol counselors, and family and peer support advocates.
- Available services will include individual and group treatment, medication support, crisis intervention, case management, vocational rehabilitation services, and, if necessary, operational costs for enhanced non-Medi-Cal-reimbursable staffing.
- Peer support and family involvement will be a primary focus of the program promoting community re-integration before discharge from the program. For example, there will be Project Return, a client-run self-help group with peer bridgers, and DMH peer support advocates and bridgers.
- The MHSA, Medi-Cal, Medicare, or other available third party revenue will support the program.
- Outcomes will be consistent with those outlined in the CSS plan.

Implementation of the program will assist clients from acute inpatient, institutional and intensive residential settings to safely reside in the community with mental health and supportive services.

Investments to **increase housing options for adults with severe and persistent mental illness:** The Housing Systems Development initiative is designed to fund housing specialists throughout the County, and the service and operational costs of two

new residential programs, Safe Havens, for homeless persons who have mental illness with co-occurring substance abuse disorders.

Housing Specialists: The Department's successful Integrated Services for the Homeless Mentally Ill program, AB 2034, has utilized housing specialists effectively in the delivery of housing services to its homeless members. The AB 2034 program has substantiated that housing specialists are extremely effective in securing and retaining private market rate housing for homeless individuals with mental illness. Accordingly, the housing specialists funded through the MHSA will adopt the model of service delivery employed by the AB 2034 Program. The housing specialists' functions will include, but not be limited to:

- Assisting individuals complete applications for rental subsidies and move-in assistance, housing programs or private rental agreements
- Assisting individuals to prepare for interviews with prospective property owners or housing managers
- Accompanying and assisting individuals with housing searches
- Acting as an advocate and negotiator for individuals with poor credit and poor housing histories (i.e. evictions or lack of a housing tenancy) while establishing a professional relationship with property owners and managers
- Averting possible evictions by maintaining a professional relationship and promptly addressing the concerns of the property owners and managers that may arise
- Working closely with individuals' PSCs or outpatient clinicians to assist with housing retention efforts and facilitate communication among the involved parties

In keeping with the Department's system transformation efforts, Housing Specialists will provide housing placement services not only for homeless individuals and families, but also those living in institutional settings, ARFs, Sober Living Homes and other community placements that seek to live in a more independent living situation. Assistance will also be given to those who are living in temporary, often overcrowded, situations with family or friends.

It is the goal of this program to have two Housing Specialists in each of the Department's eight Service Areas (SA). Currently, there are two existing Housing Specialists, one in SA 5 and one in SA 8. Accordingly, MHSA funding will be used for 14 new Housing Specialist positions for adults and older adults. Recognizing that each SA has unique characteristics and needs, the SA has the discretion to utilize a staffing pattern that is consistent with the needs of its particular area, including the recruitment of clients and/or family members.

Development of Residential Programs for the Homeless Mentally Ill/ **Safe Havens:** Safe Havens provide a safe and non-threatening environment for chronically homeless individuals with mental illness and possible co-occurring substance abuse disorder to seek refuge. Each program will provide a 24-hour staffed facility offering up to 25 semi-private accommodations for men and women for an indefinite period. The programs are

intentionally kept small, to provide for more intimacy and opportunity to engage with residents, and embrace a high-tolerance, low-demand service philosophy. Due to the high levels of disability among the targeted population, the programs offer diverse, specialized services that are flexible to address the non-linear progression of mental illness and substance addiction. Accordingly, staffing for these programs will include individuals with similar backgrounds and experiences as those individuals being outreached. Specifically, staffing will include clients and family members who have experienced homelessness and/or substance abuse. The capacity and configuration of the Safe Havens will depend heavily on the site, as some programs also provide supportive services on a drop-in basis to eligible persons who are not residents. From a housing perspective, these programs are focused on preparing and moving clients into more appropriate forms of support, such as Shelter Plus Care, where they can benefit from permanent supportive housing. Safe Haven residents can stay indefinitely, although many move on within six months.

Jail Transition and Linkage Services: Jail Transition and Linkage Services are designed to outreach and engage/enroll incarcerated individuals receiving services from Jail Mental Health Service or others with mental illness referred by Mental Health Court Workers, Attorneys, and family members, into appropriate levels of mental health services and supports, including housing and employment services, prior to their release from jail. The goal of these services is to prevent release to the streets, thus alleviating the revolving door of incarceration and unnecessary emergency/acute psychiatric inpatient services. A Linkage and Engagement Team will identify those individuals who meet the criteria for FSP programs and coordinate the referral and linkage with FSP programs. For those individuals requiring assistance but not meeting the criteria for FSP, the team will link the individuals with a Service Area Navigator and/or appropriate program(s). Individuals interested in seeking employment, including those being referred to FSP programs and those linked with a Service Area Navigator will be referred to one of four designated partner WorkSource Centers administered by the City of Los Angeles Community Development Department.

The Linkage Team will interview and assess referred clients to determine level and type of need, develop a release plan, coordinate with Service Area and Service Area Navigators or FSP programs for appropriate placement, and refer to one of the designated WorkSource Centers, when indicated. All Linkage services will take place while the client is incarcerated, thus ensuring a seamless transition from jail mental health services to community based services upon release.

The Jail Linkage and Engagement Team will also be responsible for following clients who are referred to and placed in a DMH Specialized Shelter Program upon their release from jail. The team will work towards transitioning these individuals from the Specialized Shelter to enrollment in a FSP program.

We estimate that, currently, approximately 77 inmates being released from the jail each week need linkage to MHSA community-based services. In order to serve this volume of inmates, the Jail Linkage and Engagement Team will consist of a multi-disciplinary team

of professional, paraprofessional, and support staff that will report directly to the County Resource Management District Chief. The professional and paraprofessional staff will be assigned to each SA and will work in collaboration with the Jail Mental Health Staff assigned to the same SA.

The Rehabilitation Counselors on the Jail Linkage and Engagement Team will be assigned to two Service Areas each and will work in collaboration with the Jail Mental Health Staff assigned to the corresponding Service Area. In addition, the Rehabilitation Counselors will be co-located regularly at the four designated partner WorkSource Centers in order to coordinate the transition from jail to the community.

The Rehabilitation Counselors will provide the employment component of the Jail Transition and Linkage Services. Their responsibilities will include:

- Co-locate at a designated WorkSource Center 3 to 4 days a week providing a full complement of services (clinical, employment and case management)
- Meet with DMH clients initially engaged in the jail and those referred from FSP programs at the WorkSource center.
- Participate in co-case management of DMH clients with WorkSource center staff.
- Participate in WorkSource Center Orientation, presenting on mental health services available to WorkSource customers
- Provide referrals for WorkSource customers to appropriate mental health or substance dependence services.
- Provide training to WorkSource Center staff and partner staff on identified topics relating to mental health such as conflict resolution, stress management.
- Include WorkSource Center staff and interested partners in any appropriate training opportunities provided by the County Department of Mental Health or its partner agencies.

Systems Development Investments for Older Adults 60+

Systems Development investments for older adults are intended to help initiate a comprehensive system of care for older adults with mental illness. The current system is clearly inadequate to meet the needs of this growing population in Los Angeles County.

Systems Development investments for older adults will address the needs of individuals with long-term serious mental illness who have been part of the adult system of care and are now aging into the older adult system of care – as well as individuals who have late-onset mental illness.

Transformation Design Team: The Transformation Design team intends to utilize Community Services and Supports funding to transform the Older Adult (OA) System of Care in Los Angeles County. "Transformation Design" dollars will be used to identify, disseminate and evaluate values-driven, evidence-based and promising clinical services for older adults. The ability to promulgate and evaluate emerging practices is particularly critical in Los Angeles County, which is known for the rich cultural, ethnic and linguistic

diversity of our population. It is an area where promising culturally relevant practices may evolve based on the wisdom and experience of clinicians, peers, family members and alternative/indigenous caregivers. The Transformation Design component of the CSS plan will create an opportunity to identify and develop promising practices, supporting those who may have knowledge based on experience – but who may lack the ability to objectively evaluate the success of their approaches.

The CSS Transformation Design program will focus on practices that are transformative and consistent with priorities identified in the State's CSS plan. Some examples include:

- Recovery-oriented approaches specific to older adults, including employment, volunteerism, and continuing education programs
- Evidence-based integrated treatment of co-occurring disorders in older adults – including new programs that will be developed due to changing patterns of substance abuse and mental illness stemming from the aging of the "baby boomers"
- Culturally sensitive evidence-based or promising practices for assessing and treating older adults, including assessment strategies that integrate primary healthcare providers in the treatment team
- Use of community based, culturally sensitive older adult family and peer support in the delivery of services which includes the following: peer advocates, peer counselors, family members, and alternative / indigenous caregivers
- Best practices for transition age adults including training and consultation services for adult providers working with transition age adults who will "age in place" within the adult system of care, as well as development of integrated transition programs that will assist adults as they move from ASOC into OASOC programs.

The opportunity to transform the Older Adult System of Care in Los Angeles County comes at a crucial moment. Currently, the continuum of care is comprised of one countywide assessment team and five specialized contract providers serving older adults. Specialized treatment services for this age group are located in only three of the County's eight Service Areas with general services located in another two Service Areas. While the Department has focused on developing core staff competencies in assessment and treatment of older adults, recent professional and social changes are dramatically impacting the field. More specifically, the rapid expansion of evidence-based practices and the significant changes in the cohort of individuals entering the older adult age group (due to the baby boomer generation who are now reaching the age of 60) necessitate changes in program development and outcome monitoring as a basis for Community Services and Supports. The Transformation Design strategies proposed are intended to benefit two subgroups identified within the older adult group: individuals 60-64 years of age, and those who are 65 and older. In addition, proposed services will focus on the highly specialized needs of individuals over the age of 75 – a group that is growing dramatically.

In order to accomplish these goals, individuals with expertise in design, development and evaluation of programs for older adults will be recruited. Additional dollars will be used to retain the services of consultants with specialized expertise such as suicide among the elderly, psychopharmacology and aging, and integrated treatment of co-occurring disorders in older adults. Staff will develop baseline information about existing services and needs, identify evidence-based or promising practices, and evaluate the success of strategies that are implemented. Additional input will be garnered from peer and family advocates.

The proposed Transformation Design investment is expected to reach well beyond programs implemented through the Mental Health Services Act. The work of the Transformation Design program will impact older adult services with existing funding sources – thereby significantly leveraging resources available through the Mental Health Services Act.

Field Capable Clinical Services: Development of field capable clinical services throughout Los Angeles County is a priority for the Older Adult System of Care. As noted above, specialized treatment services for older adults and their families currently exist in only three of eight Service Areas, with general services provided in another two service areas. Field capable services, delivered by interdisciplinary teams of professionals trained to work with older adults, will be offered in community locations preferred by the client including homes, senior/public housing complexes, senior centers, mental health clinics and primary care physicians' offices. Specific services include:

- Outreach and engagement
- Bio-psychosocial assessment
- Individual and family treatment
- Medication support
- Linkage and case management support
- Specialized treatment for Co-occurring disorders
- Peer counseling, family education and support

Field capable clinical service teams will also include consultation by gero-psychiatrists, geriatricians, gero-pharmacists, and neuro-psychologists. Field capable clinical service teams will coordinate care with available older adult appropriate psychiatric emergency services and conservatorship support (both LPS and probate).

Field-capable clinical services will address the needs of older adults who are between the ages of 60 and 64, and those who are 65 years and older. As the program develops, specialized services for those who are over the age of 75 will also become a focus. Stakeholders recommend the funding of field capable clinical services as they are currently unavailable in many areas within Los Angeles County. In addition, expansion of services to older adults will prioritize the needs of those who have traditionally been unserved or underserved. This includes those clients who need much engagement to access and maintain services (e.g. paranoid individuals who are fearful of "the system")

individuals who are severely mentally ill and/or isolated, self neglecting or abused, and older adults who are homeless. Finally, field capable clinical services staff will focus on individuals who are uninsured, undocumented immigrants and/or monolingual in a language other than English. Additional sources of funding for this program will include MediCal and Medicare.

In contrast to many existing programs that are primarily clinic-based, field capable clinical services funded through the MHSA, will be dedicated to ensuring that services are provided in locations preferred by clients. This will include, for example, the option of co-locating services with physical healthcare providers – or delivering services in collaboration with primary medical providers.

Older Adult Service Extenders: Reaching older adults in a manner that is sensitive to their needs and culture includes providing services in homes, residential facilities and other community locations. Each Service Extenders program will recruit paid and/or volunteer peer counselors and family members who will address concerns for older adults and their families including:

- Isolation of the home-bound elderly
- Loss of support system due to the death and disability of family and peers
- Disorientation and cognitive decline that occur when older adults must navigate the movement between levels of care and institutions (as when an older adult is hospitalized or must enter a skilled nursing facility or assisted living center)
- Difficulties for family members who require mental health information and emotional support to cope with the changing circumstances of their loved one(s)

Assistance for family members will help reduce their stress level, and will also help ensure that they stay connected and in relationship with the client.

Service extenders are included within the Older Adult Community Services and Supports plan. The following components of the Service Extender Program are designed to address the needs outlined above:

- Peer Counselors/peer bridgers who are part of field-based clinical teams, will be hired to visit older adults in their residences. They will provide support and counseling, helping to reduce isolation. Peer counselors will also be trained to identify and intervene with older adults who are at risk of abuse, neglect or disability, thereby increasing the safety net for those who are most vulnerable. Peer counselors/peer bridgers will also support and assist older adults who are transitioning to and from hospitals and other residential facilities (e.g., returning home from hospital). As members of field-based clinical teams, they will provide continuous support, helping the older adult adjust to new settings and establish or reestablish linkages with individuals and services.
- Volunteer peer counselor programs may be developed by specialized older adult agencies. Staff will be hired to train, monitor and supervise volunteer peer counselors for these specialized programs.

- Family members who have life experience supporting older adults with mental illness will be trained to provide education and support groups for others.

All components of the Service Extenders program will address the needs of distinct groups of older adult mental health consumers and their families:

- those who are 60 through 64 years of age;
- those who are between 65 and 84 years of age; and
- those who are above the age of 85.

Older Adult Training: This program for older adult service providers will be dedicated to changing attitudes and knowledge regarding recovery, peer support and emerging best practices for culturally diverse older adults. In collaboration with the Transformation Design Team program described above, the CSS Training Program will provide education to professionals, peers, family members and community partners (e.g., primary healthcare providers, first responders, staff of senior centers) regarding values-driven and promising clinical services that support client-selected goals.

In order to accomplish the objective of developing integrated treatment models for older adults, the training program will involve direct training and cross-training of a variety of individuals including (but not limited to):

- Clients who will serve as peer counselor/peer bridgers
- Family members who will lead support and educational groups for other family members in the community
- Primary caregivers and other allied health professionals
- First responders
- Staff of community-based organizations such as senior centers, in-home support services and faith-based organizations
- Multidisciplinary mental health staff

The training topics and curriculum will be designed to address the multi-system characteristics of mental health services to older adults, with a bio-psycho-behavioral approach. Components include the following:

- Transformative training focused on changing attitudes in support of peer counseling/peer bridging programs (see section on Service Extenders)
- Education for primary care and other health providers to increase coordination and integration of mental health, primary care and other health services

Additional topics that support the values and priorities of the Mental Health Services Act include:

- Effective interventions; evidence-based and promising practices for culturally diverse populations
- Recovery models for older adults

- Integrated treatment of co-occurring disorders among older adult populations
- Challenges for transition age adults
- Employment and volunteerism for older adults
- Housing options for older adults
- Understanding of benefits; benefits establishment
- Stigma, ageism: influences on providers, clients and family
- Developmental/life cycle issues in aging
- Cultural Competence and Older Adult Mental Health Services
- Assessment methods/screening tools for ethnically and linguistically diverse groups

CROSS-CUTTING INVESTMENTS FOR ALL AGE GROUPS

In addition to the age-specific recommendations for systems development, delegates also developed recommendations for several initiatives that will benefit all age groups. These include recommendations for:

- Service Area Navigator Teams;
- An expansive array of alternative crisis services;
- Planning efforts and outreach and engagement efforts; and
- Administration of the CSS plan.

Service Area Navigator Teams

One of the foundational premises of the Los Angeles County CSS plan is a belief that professionally delivered, publicly funded human services, by themselves, cannot deliver the outcomes we seek for people who struggle with mental health needs.

Funds from the MHSA will ultimately represent only 15-20% of the total LA DMH budget; the CSS plan represents less than 10% of the Department's budget. As promising as these new funds are, if we are committed to achieving the outcomes of the MHSA for all people in Los Angeles County who struggle with mental health issues, we must build structures that help people more quickly identify both the professional and community-based services and supports they need to advance their recovery and strengthen their capacity for wellness.

Service Area Navigator Teams will be a crucial structure to help people find the formal and informal supports they need. We will begin by establishing one Service Area Navigation team in each of the eight Service Areas. Team members and those who support them will:

- Engage with people who need services and their families to help them quickly identify currently available services, including supports and services tailored to the particular cultural, ethnic, age, and gender identity of those seeking them;

- Recruit community-based organizations and professional service providers to join an active and ever growing locally-based support network for people in the Service Area, including those most challenged by mental health issues;
- Follow-up with people with whom they have engaged to ensure that they have connected with support structures and received the help they need;
- Use information technology and other means to map and keep up to date about the current availability of services and supports in the Service Area;
- Engage in joint planning efforts with community partners, including community-based organizations, other County Departments, intradepartmental staff, schools, and health service programs, with the goal of increasing access to mental health services and strengthening the network of human services available to clients of the mental health system;
- Collaborate with the Countywide Resource Management, Residential and Bridging Services, and Jail Transition and Linkage Services initiatives to further facilitate the return to the community of those individuals that have primarily been involved with psychiatric emergency/acute inpatient and institutional care; and
- Promote awareness of mental health issues, and the commitment to recovery, wellness, and self-help that lies at the heart of the Mental Health Services Act.
- Have familiarity with and the capacity to make appropriate linkages to the wide array of services and supports to help people with co-occurring disorders, with particular emphasis on substance abuse disorders.

Members of Service Area Navigator Teams will regularly visit community organizations, emerging and well-established health and mental health programs, Law enforcement agencies, schools, courts, residential facilities, NAMI chapters, self-help groups, client advocacy groups, and others. This model provides the beginning infrastructure to implement a system of care that is responsive to the local needs of communities, clients and families.

The Navigator teams in each Service Area will consist of a balance of community workers, people who have received services, family advocates, family members, and mental health professionals. While the precise design of these teams will vary by Service Area, reflecting each Area's particular local character and needs, each team will recruit members who together have substantial familiarity and expertise with all age groups, including the particular challenges facing those age groups and the distinct characteristics of the support networks for each.

One common aspect of these teams agreed to by the delegates focused on the role and deployment of transition age youth specialists. These specialists would be divided into two groups: specialists deployed at the Transition Resource Centers (TRCs) and Drop-in Centers across the County, and specialists who "float" between the camps, shelters, and other places that attract un-served and under-served TAY with serious mental illness/severe emotional disturbances.

These specialists will be part of the Service Area teams even though they are deployed in different places. These specialists should have direct lived experience with many of

the issues facing transition age youth, and the relational skills to develop easy rapport with TAY.

Some of the key responsibilities of these TAY specialists would include:

- Helping to expand the capacity of the TRCs and other structures to outreach to and become safe places for TAY, developing current active knowledge of the range of resources available for TAY.
- Conducting MediCal eligibility screening and initial clinical assessments for young people who may not have been in any system up to this point (different from the expectations for the children and adult community education and outreach workers).
- Earning the trust of TAY and making referrals to organizations that will provide effective assistance.
- Advocacy and short-term case-management.

Alternative Crisis Services

Over the past several years, the Psychiatric Emergency Services (PES) in all County hospitals have been challenged with overcrowded conditions caused by a severe lack of community resources, particularly for those who do not have insurance. As County hospitals became impacted, beds in local community hospital emergency rooms filled with individuals who had a mental illness, many of whom were also homeless and/or experiencing a co-occurring substance abuse disorder. The overcrowded emergency room conditions and the lack of essential community resources for aftercare have combined to create a crisis in the emergency system of Los Angeles County.

Given this crisis, delegates have agreed, consistent with the Board of Supervisors commitment to insure long-term transformation of these services, to recommend a significant investment of systems development funds to create a range of alternative crisis services to relieve the crisis affecting Psychiatric Emergency Services in Los Angeles County.

The recommendations are intended to significantly improve these services for youth and their families, and adults and older adults. Some delegates remain skeptical about the potential for these services to meet the threshold requirements of the CSS plan to reflect a commitment to recovery and wellness, and to reduce institutionalization of people with severe and persistent mental illness and severe emotional disturbances. Considerable detailed planning must take place before the recommendations embraced by the delegates can be implemented on a daily, working basis in ways that reflect these threshold commitments to recovery and wellness.

This recommended investment includes recommendations for four related but distinct initiatives:

- Urgent Care Centers;
- Countywide Resource Management;

- Residential and Bridging Services; and
- Enriched Residential Services.

Urgent Care Centers: The Urgent Care Centers (UCC) program, currently being explored and developed at several sites in the County—e.g., at Augustus F. Hawkins Mental Health Center and Olive View Medical Center—will provide intensive crisis services and integrated treatment for co-occurring disorders (COD) to individuals who would otherwise be brought to the Department of Health Services (DHS) County hospital Psychiatric Emergency Services (PES). These individuals are less likely to require psychiatric hospitalization or medical care, but are in need of medication management, stabilization and linkage to ongoing community-based services. Providing crisis intervention services to clients in a UCC with a focus on recovery and linkage to ongoing community-based mental health services will divert clients who would otherwise go to the PES and further aggravate overcrowded conditions in the PES. Clients evaluated in PES are most often placed on 72-hour detentions, often resulting in unnecessary and lengthy involuntary inpatient treatment. This alternative crisis service will promote the provision of mental health care and integrated treatment for COD in voluntary treatment settings that are recovery oriented.

Emphasis will be on highly specialized and intensive interventions, including rapid stabilization, outpatient detoxification, engagement with mental health and substance abuse specialists, and linkage to services within local communities. The length of patients' stay will be no more than 23 hours. Services include:

- Comprehensive psychiatric assessment, including substance abuse assessment
- Basic physical assessment, including assessment of symptoms related to substance abuse
- Referral to medical treatment when necessary
- Individualized mental health treatment and services
- Limited detoxification services
- Group interventions, e.g., AA meetings on the unit
- Engagement of clients with co-occurring substance abuse problems
- Crisis intervention, including family interventions when needed
- Medication management
- Housing assessment and referrals for emergency, transitional, permanent housing
- Referral to Full Service Partnership (FSP) programs
- Assessment of financial situations and initiation of benefits establishment process when indicated
- Referral to substance abuse programs, particularly those with capacity to admit persons with co-occurring mental illness
- Referral to employment, self-help, money management, and community resources for recreation and social interaction, etc.
- Referral and linkage to community mental health centers in clients' communities; linkage to clients' existing service providers
- Referral to Wellness Centers and Client Run Support programs

Surveys have shown that approximately 70 percent of clients in PES have substance abuse problems. The COD component of the UCC plan, through the DHS Alcohol and Drug Program Administration (ADPA), will provide much-needed on-site substance abuse assessment and referral capabilities and will begin to expand off-site capacity in community-based treatment and recovery programs for clients with COD who present in emergency settings. These services will include detoxification, stabilization/residential, intensive outpatient and transitional housing, along with other supportive services tailored to meet individual client needs. Clients will be provided with or assisted with accessing the following types of integrated treatment services:

Adolescents (ages 12 to 17) – A continuum of care, offering a full range of intensity and evidence-based approaches, needs to be expanded to address this population. Services should include the following:

- Licensed residential treatment services offering 24-hour stabilization, clinical case management, and therapeutic counseling; maximum treatment stay would be 60 days.
- Intensive certified integrated outpatient counseling services offering supportive placement, therapeutic individual, family and group counseling, and client supportive services tailored to meet individual client needs.
- Integrated outpatient services that are less intensive offering case management services and client supportive services tailored to meet individual client needs.
- Ongoing recovery support services that offer a broad array of programs supporting youth and their families, such as relapse prevention sessions, self-help and peer support group meetings and other strength-based activities promoting resiliency and achievement of recovery and wellness.

Adults (ages 18 and above, including transition age youth age 18 and over, adults, and older adults) – A full continuum of integrated treatment services will include detoxification, stabilization, intensive outpatient services with supportive housing, and ongoing recovery support. The following continuum of care, offering a full range of intensity and types of evidence-based integrated mental illness and substance abuse services is needed to comprehensively address this population's specific needs:

- Medically supported short-term residential detoxification services that provide stabilization and referral.
- Licensed residential services offering 24-hour clinical and integrated treatment services.
- Intensive certified outpatient counseling services offering clinical individual, family and group counseling services, case management and supportive housing assistance.
- Certified outpatient counseling services that are less intensive, offering client supportive services tailored to meet individual client needs.
- Ongoing recovery support services that offer a broad array of programs supporting persons in recovery and may follow completion of a structure treatment programs. Services may include relapse prevention sessions, self-help

and peer support group meetings, and other activities promoting resiliency and achievement of recovery and wellness.

Expected outcomes of the UCC include the following:

- Reduced overcrowding in LA County PES as measured by reduced length of stay and reduced daily census
- Reduced number of adverse events in County hospital psychiatric emergency rooms
- Reduced hospitalization rates among identified intensive service recipients (high utilizers/ISRs) who are served by the UCC
- Reduced utilization of PES by identified high utilizers
- Increased community tenure (time spent living and working in the community) among people served by the UCC
- Change in substance abuse behaviors (uses less, attends meetings, classes, etc.)
- Enhancing and strengthening access, linkage and transition between crisis services and community based programs
- Planning, developing, and implementing programs that support the goal of increasing access to community-based mental health services, i.e. supportive residential and housing programs, and enrollment in FSP for persons exiting higher levels of care
- Identifying and addressing systemic barriers to providing coordinated mental health services with programs, providers, County, and State departments and agencies

Countywide Resource Management Program: The Countywide Resource Management Program, an administrative Department of Mental Health (DMH) program, will provide overall administrative, clinical, integrative, and fiscal management functions for the Department's acute inpatient (uninsured persons), and adult/older adult long-term institutional, crisis residential, intensive residential and supportive residential (IMD step-down) resources, with daily capacity for over 1200 persons. The Department's Interim Funding Program and the proposed Residential and Bridging Services, and Jail Transition and Linkage Services will also be under the direction of this program.

By centralizing the management of these Countywide resources, this program will be vital to the success of the CSS plan, enhancing individuals' ability to avoid or reduce lengths of stay in involuntary treatment and institutional settings. Staffing for this initiative will consist of a Mental Health Clinical District Chief and a Mental Health Analyst.

The Countywide Resource Management Program's responsibilities will include:

- Being responsible for overall administrative, clinical, integrative and fiscal aspects of all resources within the program;

- Coordinating functions to maximize client flow between higher levels of care and community-based mental health services and supports;
- Planning and implementing programs on an ongoing basis that promote transition of individuals residing in institutional care to community-based programs that promote recovery and reduce rates of hospitalization, incarceration, and placement in Institutions for Mental Disease (IMD);
- Negotiating and managing Countywide, multi-million dollar contracts with hospitals, long-term care and community providers;
- Directing and coordinating program reviews and evaluation of outcomes to ensure that services provided address the unique needs of clients served, including those with co-occurring behavioral disorders, and that they are in compliance with the terms of the contracts and County, State, and Federal mandated standards; and
- Interfacing with other County, State, and Federal departments/agencies, the Mental Health Commission, Service Area (SA) administrations and Advisory Committees, NAMI, and other stakeholders regarding program resources and coordination in order to ensure appropriate utilization and coordination of resources.

Current fragmentation of mental health service delivery contributes to over-reliance on costly crisis and inpatient resources, as well as unnecessary incarcerations. This program will provide enhanced coordination, linkage and integration of inpatient and residential services throughout the system thereby enhancing the goals of the MHSA by reducing re-hospitalization, incarceration and the need for long-term institutional care, while increasing the potential for community living and recovery.

Residential and Bridging Services: The Residential and Bridging Services will provide DMH program liaisons and peer advocates/bridgers to assist in the coordination of psychiatric services and supports for TAY, adults and older adults being discharged from County hospital psychiatric emergency services and inpatient units, County contracted private acute inpatient beds for uninsured individuals, UCCs, IMDs, crisis residential, intensive residential, and supportive residential (IMD step-down) facilities. The program will ensure linkage of these clients upon discharge, with appropriate levels and types of mental heath and supportive services, residential, substance abuse, and other specialized programs. The program will promote the expectation that clients must be successfully reintegrated into their communities upon discharge and that all care providers must participate in client transitions. The Countywide Resource Management Program will manage and coordinate the Residential and Bridging Services.

This program will utilize CSS funding to support the following strategies:

- In-patient settings staff will identify those Intensive Service Recipients (ISR) enrolled in Full Service Partnerships or similar programs—e.g., AB 2034 and Assertive Community Treatment (ACT) programs—or served by other outpatient service providers and link these providers to the hospital treatment teams for the purpose of coordinated treatment and discharge planning.

- The liaisons and peer advocates will collaborate with inpatient, emergency services, and residential treatment teams, to assist in developing after care plans for those clients identified with intensive and complicated service needs that are not already in FSP/AB 2034 or ACT programs.
- The program will coordinate discharge planning with Service Area Navigators to ensure that individuals have access to appropriate resources in their geographical areas.
- Liaisons and advocates will work collaboratively with community providers to facilitate linkage to community-based resources. This includes coordination with substance abuse programs, mental health clinics, residential providers, FSPs, self-help groups and bridging services. The program will ensure continuity of care and consumer support during the discharge process.
- Staff will assist in benefit establishment activities to ensure applications for benefits are initiated in a timely manner. This will include advocacy and identification of system barriers that prevent the establishment of benefits.
- The program will identify system barriers, including social and financial barriers, to successful re-integration of individuals into their communities and work with other departmental programs and community agencies to resolve these barriers.
- The program will employ a recovery approach toward treatment with a strength-based focus that empowers clients to develop their goals toward community re-integration, skills to become self-sufficient and the capacity to increase current levels of community functioning.
- Peer support and family involvement will be an important aspect of the program. For example, the program will employ peer advocates and there will be client-run self-help groups providing support and peer bridging.

Enriched Residential Services: The Enriched Residential Program will be a secure 48-bed augmented, licensed Adult Residential Facility (ARF) that will serve DMH clients, 18 to 64 years of age, who are ready for discharge from acute psychiatric inpatient units, Crisis Residential facilities or Institutions for Mental Disease (IMD). This program, provided by a DMH contractor, will increase the Department's community-based intensive residential resources that are focused on breaking the cycle of costly emergency and inpatient care and promoting successful community re-integration.

The program will target those individuals in higher levels of care who require intensive mental health supportive services to transition to stable community placement and prepare for more independent community living. Some of the essential characteristics of this program will include:

- The anticipated length of stay will be two to six months.
- The program will have 24/7 capacity for emergencies and specialized programming.
- Staffing will include licensed mental health professionals, mental health workers, certified drug and alcohol counselors, and family and peer advocates.
- As clients progress, they will be able to transition into Full Service Partnerships and independent living and participate in vocational activities in the community.

- The program will provide individual and group treatment, medication support, crisis intervention, case management, and vocational rehabilitation services.
- Peer support and family involvement will be a primary focus of the program promoting community re-integration before discharge from the program. For example, there will be Project Return, a client-run self-help group with peer bridgers, and DMH peer support advocates/bridgers.
- Outcomes will be consistent with those outlined in the CSS plan.

Planning, Outreach and Engagement

From the outset of the CSS planning process, delegates planned on assigning a portion of the on-going funds to support on-going *planning*, *efforts to engage communities* traditionally un-served by the mental health system, and work to *build the infrastructure needed to track outcomes* over time. When the California Department of Mental Health created the opportunity of one-time funds, and designated planning and outreach and engagement as permissible uses of these funds, delegates developed a plan to:

- Develop a very aggressive outreach and engagement campaign through the second half of FY 2005-06 with one-time funds;
- Build essential planning and outcomes infrastructure with one-time funds; and
- Allocate approximately 5% of the on-going funds in FY 2006-07 and FY 2007-08 ($4.5 million each year) to on-going planning and outreach and engagement efforts.

Administration costs

The delegates agreed to estimate the administrative costs the Department will incur during the first 3 years of administering the overall Community Services and Supports initiative at $4.5 million per year. Additional plans developed under the Mental Health Services Act will require additional administrative costs.

Delegates distinguished between administrative costs the Department will incur in administering the overall initiative and administrative costs providers will incur administering particular programs. While delegates agreed that provider rates should make provision for reasonable administrative costs, several delegates raised the issue of costs that providers incur in *designing* a program that often cannot be recouped through service rate structures. Delegates agreed to examine this issue in the design and implementation phases of each of the initiatives funded under the Community Services and Supports plan.

ONE-TIME FUNDING INVESTMENTS

Delegates reached consensus on six priority investments for the projected one-time that may be available to Los Angeles County. We understand that all efforts funded through one-time funds must be completed by June 30, 2006. The priority investments include:

- A Prudent Reserve;
- A Housing Trust Fund;
- One-time Training and Workforce Development Initiatives;
- Outreach and Engagement investments;
- Planning and Outcomes infrastructure investments; and
- System infrastructure.

We believe all of these investments are specifically allowed under the guidelines for one-time funds as outlined in DMH Letter No. 05-06, dated September 2, 2005.

A Prudent Reserve: The Mental Health Services Act legislation specifically calls for the establishment of a Prudent Reserve to help counties weather year-to-year fluctuations in funding for the MHSA. DMH Letter No. 05-06, dated September 2, 2005, sets an ultimate target for this reserve at one-half of a County's first year CSS allocation. For Los Angeles County, that would equal $44,896,400. While we have initially recommended $9,046,400 be invested in this reserve fund, to the extent that we do not meet our other one-time funding spending targets, we expect to be able to move the unspent one-time funds into the reserve fund to insure that these funds are not lost to Los Angeles County.

Housing Trust Fund: Delegates recommend allocating $11.6 million of one-time funds to help capitalize a Housing Trust Fund to support the development of new permanent supportive housing for individuals with psychiatric disabilities, particularly those individuals who are homeless or are living in Residential Care Facilities, Institutions for Mental Disease and other settings such as Sober or Collaborative Living facilities.

The MHSA funds dedicated to the Trust Fund account will be used to:

- Leverage other local, state, and federal financial resources for developing permanent, affordable, supportive housing for all age groups, including children, youth and families, transition age youth, adults, and older adults.
- Provide on-going rental subsidies and the on-site supportive services necessary for special needs housing developers to leverage millions of dollars in capital funds. Long-term commitments for project-based vouchers or other types of rental subsidies are necessary for special needs housing developers to obtain long-term financing for the capital costs of new projects. Historically, federally sponsored Section 8 vouchers have served this purpose. However, in recent years there has been a dramatic decrease in the availability of Section 8 tenant and project-based vouchers, a trend that is expected to continue. The Housing Trust Fund will fill a crucial gap in commitments for rental subsidies and supportive services required for the development of permanent, affordable and safe supportive housing.
- Provide emergency housing for emancipated homeless youth during the outreach and engagement process
- Fund consultants to assist in planning strategies to minimize any neighborhood opposition to special needs housing in their neighborhoods.

The Department, in conjunction with a Housing Trust Fund Advisory Board (HTFAB), will establish specific administrative and program guidelines outlining the purposes of the Housing Trust Fund, the targeted beneficiaries, basic eligibility requirements for receiving funds, the funding process, and the mechanism for overseeing the Trust Fund operations. The Housing Trust Fund Advisory Board will include representatives from County and local governments, and other appropriate stakeholders. The Board will include significant representation from clients and family members. Additionally, the Department will encourage a broad range of consumer input on the HTFAB. Special attention will be given to engage homeless and formerly homeless individuals at different points in their recovery and from different types of housing initiatives, age groups, and minority populations.

Of the recommended $11.6 million for this housing initiative, delegates recommend using $100,000 of these resources to fund a planning and design initiative. The purpose of this planning and design work, called the NIMBY (Not in My Backyard) initiative, is to develop an on-going approach for responding to local concerns and resistance to the siting of permanent supportive housing for people with severe and persistent mental illness.

Workforce Training and Development: Meeting the aggressive implementation timelines outlined in the Los Angeles County CSS plan will require a workforce committed to recovery, grounded in principles of cultural sensitivity and competency, and dedicated to achieving positive outcomes for those most severely affected by mental health issues. The purpose of this one-time funding proposal is to jump start efforts in Los Angeles County to strengthen its mental health workforce in ways that will insure the success of the Mental Health Services Act.

The three target groups for this proposal include:

- People who are not yet working in the mental health system who are committed to getting a job working somewhere in the system
- People who are currently working in the mental health system or in partnering organizations, agencies, and departments
- People who are in degree-granting programs for whom there is a documented urgent need

1. **Target group:** People who are not yet working in the mental health system
   a. This group:
      - Includes people without bachelor degrees as well as people with bachelors degrees
      - Will include substantial numbers of people who receive services, family members, including caregivers of young children, and members from underserved populations, including ethnic and racial groups.

   b. The outcomes sought for this group as a result of this proposal include:
      - A job in the mental health system providing effective mental health services, including but not limited to jobs with:

- The Department of Mental Health
- Community-based organizations providing mental health services
- Contract providers
- Partner departments and organizations

- Increased understanding and commitment to the concepts of wellness, recovery, and resiliency as part of their work

c. The basic design for this population
- An intensive training and orientation program (or programs) that would include at least 4 basic components:
  - Classes to introduce participants to the essential components of the mental health system, and the essential elements of mental health services grounded in a commitment to wellness, recovery, and resiliency.
  - Experiential learning opportunities for participants to experience first-hand one or more aspects of the mental health system
  - Peer and mentoring support to help participants make sense of and learn from their experiences
  - Support for securing a job at the conclusion of the program

- The exact design of this approach will be determined over the next several months. We will research existing models and programs to insure that we can meet the time constraints associated with the one-time funds.

d. Estimated budget: $2.5 million

2. **Target group:** People who are currently working in the mental health system or in partnering organizations, agencies, and departments

a. This group:
- Includes current staff for LA DMH
- Includes current staff for partnering organizations, agencies, and departments, including but not limited to:
  - Law enforcement personnel
  - Staff from other County departments, including Probation, Health Services, Department of Children and Family Services, Department of Public Social Services, and others
  - Staff from community agencies, organizations, and contract providers
  - Community based workers—e.g., existing Promotoras and others
- Includes people with no degrees and practitioners with advanced degrees
- Will include substantial numbers of people who receive services, family members, including caregivers of young children, and members from underserved populations, including ethnic and racial groups
- Will prioritize people who are essential in the first phases of implementation for the Community Services and Supports plan

b. Outcomes sought for this group as a result of this proposal
   - Increased understanding and commitment to the concepts of wellness, recovery, and resiliency as part of their work, including their responsibilities implementing parts of the Community Services and Supports plan
   - Recruit people from this group who are willing to sponsor experiential placements and jobs for people from the first target group

c. The basic design for this population
   - A consortium of stakeholders, including people who receive services, family members, including caregivers of young children, ethnic and racial groups, DMH representatives, and representatives from partnering organizations, agencies, and departments, will oversee:
     - The selection and recruitment of people to participate in the various programs and training modules.
     - The identification and selection of programs and training modules to provide the training;
     - The monitoring of learning objectives.

   - A group of consultants will be hired to:
     - Identify available programs and training modules;
     - Match priority programs and training modules to the projected participants' needs and develop reasonable learning objectives for the different groups.

   - Various programs and training modules will be identified that can introduce a diverse array of participants to:
     - The fundamental concepts of wellness, recovery, and resiliency;
     - Different cultural conceptions of mental health;
     - Other skills and orientations needed to help effectively implement the Community Services and Support plan.

d. Estimated budget: $5 million

3. **Target group:** People who are in degree-granting programs for whom there is a documented urgent need

   a. The group refined
      - People in the second year of Social Work school, Marriage and Family Therapy programs, Psychiatric Technician programs who are committed to working in the mental health system
      - People in the first year of these programs who are committed to working in the mental health system
      - People in BA programs committed to working in the mental health system
      - People in psychology degree granting programs who are fluent in one of the 11 threshold languages (other than English) and who are committed to providing mental health services to people in communities who speak that threshold language

b. Outcomes sought for this group as a result of this proposal
   - Increased understanding and commitment to the concepts of wellness, recovery, and resiliency as part of their work
   - Commitments from students who will graduate within the next year (ideal) or the next two years to provide high need services and supports in the mental health system in Los Angeles County

c. The basic design for this population
   - Agreements will be developed between the Department and several schools to provide support to students in exchange for a commitment to work for one or more years in areas of critical need in the mental health system.

   - Some examples of these programs include:
     - Social Work: The social training proposal addresses the Department's immediate need to increase the number of bilingual and multi-cultural social workers throughout the mental health delivery system in order to address the needs of underrepresented groups. Students enrolled in graduate programs in Los Angeles with field placements at DMH directly operated and contract agencies would receive stipends. Funding for stipends to support trainees with MHSA one-time funds would be converted to ongoing funding through CALSWEC once that plan is finalized by the state. Estimated budget: $1.2 million

     - Marriage and Family: The Marriage and Family Therapy proposal addresses the Department's immediate need to increase the number of bilingual and multicultural mental health providers with an emphasis in working with families. Students enrolled in graduate programs in area universities would be granted stipends for field placements in DMH directly operated or contract agencies. Estimated budget: $900,000

     - Psychiatric Technician: To further address the Department's need for bilingual and multicultural mental health providers, DMH will develop partnerships with Mt. San Antonio and Hacienda La Puente Community Colleges to implement training opportunities for students enrolled in psychiatric technician training programs. Estimate budget: $168,000

     - Psychology: Conversations will begin soon with programs to explore how to identify and provide support to psychologists who are fluent in one of the 11 threshold languages other than English and who are committed to providing mental health services to people in communities who speak that threshold language.

d. Estimated budget: $2.5 million

4. Total projected budget: $10 million

Outreach and Engagement investments: See discussion under Section 5, page 41.

Planning and Outcomes infrastructure: See discussion under Section 5, page 41.

System infrastructure: LA DMH is requesting $8,250,000 in one-time funds for infrastructure essential in supporting the CSS initiatives in the areas of information technology, transportation, critical clinic refurbishments, the purchase of modular buildings, and flexible funding to supplement infrastructure as needed. The following details the projected expenditures:

1. Information Technology Systems $3,177,000

   a. Integrated Behavioral Health Information System (IBHIS): To effectively execute the intent of the MHSA, the Department must select and implement an IBHIS that will meet the needs of both contracted and directly operated providers.

   b. Data Warehouse: It will be necessary to interface the IBHIS with other information systems to provide all of the data and functionality that DMH and its partners need to deliver services, manage operations, and complete required reports. This data would come together in a data warehouse so it can be managed and made available as appropriate.

   c. Technology Infrastructure (Two Interface Engine Servers, Additional Networked Storage, and Providers' Required Upgrade for Computer Hardware): These components are critical to data storage capacity and computer hardware needs to better position service delivery staff to handle the MHSA implementation.

2. Vehicles $1,279,000

Vehicles will be needed to meet the transportation needs of clients enrolled in Full Service Partnership programs at both contracted and directly operated clinics. The funding will purchase 73 vehicles and serve the needs of over 4,000 clients.

3. Building and Refurbishments $3,500,000

Critical refurbishments will be made to clinics, both contract and directly operated programs, in order to provide better service and an improved environment to clients. In addition, to house our Olive View Alternative Crisis Services, a modular building will be purchased.

4. Flexible Supplemental Funding $ 294,000

To be allocated based on need, between additional computer hardware upgrades, vehicles, and critical clinic refurbishments using a formula based on Full Service Partnership Clients.

Conclusion

We are excited by the opportunity under the Community Services and Supports plan to significantly improve outcomes for people in our communities who are struggling with severe mental health issues. We have a long-standing commitment in Los Angeles County to a wellness and recovery model of support and services. During the last year, we have developed a solid track record for authentic community and stakeholder engagement to address serious budget and policy dilemmas facing our mental health system. This long-standing commitment and strengthened capacity will provide, we believe, a powerful foundation for constructing an aggressive and far reaching change initiative in the coming years, beginning with this first three year Community Services and Supports plan.

As gratifying, and challenging, as the process has been to produce Los Angeles County's CSS plan, we know the real work is ahead of us: the work of delivering on the promises and hopes embedded within this plan. Even as we await the State's approval of this plan, we have already turned our attention to preparing for the design and implementation phases of the work. We invite you to join us. You can learn how to get involved by going to our website: http://dmh.lacounty.info/stp/index.html.

Thank you for taking the time to engage with this plan, and more importantly, for your commitment to help people struggling with severe mental health issues claim the power of recovery and wellness in their lives.

ATTACHMENT 1:
TABLE OF DELEGATES FOR THE FY 2005-06 BUDGET AND CSS PLANNING PROCESS

Client Coalition	2
Client stakeholder group, including client-run programs	2
Academic Partnerships	1
Alcohol and Drug Program Administration	1
Association of Community Human Service Agencies (ACHSA)	2
Representative from the Asian and Pacific Islander Community	1
Representative from the African American community	1
Chief Administrative Office	1
Children's Planning Council	1
The Courts and Public Defenders office	1
Department of Children and Family Services	1
Department of Community and Senior Services	1
Department of Health Services	1
Department of Mental Health	6
Department of Public Social Services	1
DMH Parent Advocate	1
Hospitals	2
Advocates for the homeless mentally ill	1
IMD representative	1
Representative of the jails	1
Representative from the Latino community	1
Law enforcement	1
Mental Health Advocacy Services	1
Mental Health Commission	1
National Alliance for the Mentally Ill (NAMI)	2
Representatives of the Native American community	1
Office of Consumer Affairs	1
Older Adult advocate	1
Older Adult who receives services	1
Probation Department	1
Service Area Advisory Committees 1–8 (2 delegates per SAAC; of the 16 total, at least 4 must be people who receive services and 4 must be family members)	16
State Hospital representative	1
Youth advocate	1
Additional at-large members: two with relationships with the State MHSA process; and 1 each for the African American, Asian American, and Latino communities	5
Total delegates	**63**