LOS ANGELES COUNTY MENTAL HEALTH SERVICES 2014 WHITE PAPER

Presented by the Second Supervisorial District Empowerment Congress Mental Health Committee July 2, 2012

Background

The Second Supervisorial District Empowerment Congress Mental Health Committee* endorses this white paper which envisions the Los Angeles County public mental health service system of 2014. This is intended to be a "talking paper" – to create a dialogue which envisions a system of care that meets the lofty aspirations of the Affordable Care Act.[1] While not a definitive document, it does create a working framework by which existing mental health services can be integrated with health care services in a way which best utilizes funding and workforce assets in support of those beneficiaries of public services who have mental health-related needs.

With the landscape of health, mental health, and drug and alcohol services being transformed across the nation by federal health care reform legislation, the mental health community welcomes the opportunity to support the integration of the three services domains. In California, as counties assume full responsibility for the provision of public mental health services by way of realignment legislation, Los Angeles County has the opportunity to forge a model program which integrates the three domains in support of significant improvements in the physical and emotional well-being of its public beneficiaries.

For purposes of this white paper integration of health, mental health, and drug and alcohol services is envisioned as horizontal integration – which reflects the value of each domain – working in concert with one another – in improving outcomes and achieving cost savings. This construct supports a continuum of care which, from the beneficiaries' perspective, should be experienced as seamless. At the County level there must be leadership, organizational structures, agreements, protocols, and technology and a high level of coordination among the three domains to create the infrastructure for this seamless system including removing administrative and financial barriers to wholistic, integrated, and cost effective care.

The Affordable Care Act (ACA) does not speak *per se* to large public systems like Los Angeles County which has a full continuum of health, mental health and drug and alcohol services and is believed to be the largest or second largest public beneficiary system in the nation. Rather, ACA is a mega-view for the entirety of health care reform across public and private systems (including employer-sponsored programs).

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* Empowerment Congress Mental Health Committee: Formed in 2006 by then Assembly Member Mark Ridley-Thomas, this monthly forum, which today serves the Second District, ensures that constituents are apprised of and can give voice to mental health issues of concern. Included are mental health providers, allied public and nonprofit organizations, consumers, family members, advocates, concerned citizens and others to discuss and share ideas which address mental health-related issues and advance policy and other important initiatives.

Since the Committee's inception much effort has been devoted to educating participants about Proposition 63 – the Mental Health Services Act – and how constituents can benefit. Last year the Committee served as a nexus for coalition-building on behalf of increasing services to those who are homeless and mentally ill. Currently the Committee's work is focused on the design of mental health services in concert with health care reform.

At the same time, ACA affords entities like the County the opportunity to innovate models which best meet the needs of its "safety net" service recipients. Importantly, seriously mentally ill consumers are a major cost-driver of high-cost care as demonstrated below. As for children's services, evidence-based practices are proving to be cost-bending, reducing the length of time in service while demonstrating positive outcomes, and allowing more underserved children access to needed and effective care. Effective mental health services are a vital contributor to advancing the goals of the Affordable Care Act.

At the heart of California's reform initiative should be model programs to meet the hallmark of care coordination. While much of federal health care reform dialogue has centered on the triad of primary, acute care, and hospital services and how to transcend these siloed entities, this myopic view fails to recognize the contribution of public mental health and drug and alcohol services to bending the cost curve and advancing overall health and emotional well-being for a significant number of high cost, high needs patients/consumers.

The Empowerment Congress Mental Health Committee's vision embodies the values and principles which have been endorsed by mental health stakeholders including:

- Access to mental health services at the earliest point possible
- Recognition of social and cultural context
- Resiliency and recovery as cornerstones of services
- Employment of consumers and family members who bring "lived" experience
- Prominent role of consumers and family members in planning, coordinating and evaluating system services (Project Return, National Alliance on Mental Illness)
- Building on family/consumer strengths.

The Mental Health Committee's vision also builds on Los Angeles County's mental health system assets including:

- Comprehensive system of care with stable, long-term leadership which is mission and values-driven
- Documented ability to lead and adapt to change
- Extensive county-wide network of mental health services bridging from prevention and early intervention to highly intensive treatment and support services and inpatient services
- Well-conceptualized and honored mechanisms for incorporating the views and knowledge of consumers and family members in the planning and delivery of care
- Well-trained workforce with a history of working collaboratively with community partners including provision of on-site services in a wide variety of settings
- Augmentation of public mental health services via philanthropy contributed by non-profit mental health providers
- Demonstrated positive mental health outcomes via evidence-based and promising/ research-based practices
- A large and growing percentage of mental health services delivered flexibly and conveniently in community settings

- Demonstrated permanent supportive housing outcomes for those challenged by homelessness and mental illness
- School-based services that are responsive to the needs of schools and students.

One of the many unique assets which the County mental health service system brings to the design of services for 2014 is the voice of advocates and consumer organizations like NAMI and the Client Coalition who continue to inform mental health services in ways which ensure their relevance and efficacy. These voices, along with those of other advocates, have served to radically shift mental health services away from the constrained medical model to one which embraces resiliency, recovery, and hope as cornerstones of today's mental health services.

The blueprint for the transformation of mental health services is contained in Proposition 63[2] – the Mental Health Services Act (MHSA)[*]. Strikingly, the antecedents of federal health care reform are embodied in the 2004 Act including:

- Access to culturally competent services
- Person-centered care
- Delivery of effective services based on outcomes
- Cost efficiency
- Collaboration with key partners.

Today's County mental health system is governed by the State Medi-Cal Plan, Mental Health Services Act, and a myriad of processes and forums that have included multiple stakeholders in the design of a comprehensive continuum of care that focuses on clients in need of the most intensive services to those who can benefit from early intervention and even prevention services. This continuum constitutes a network of services and providers which can fulfill the promise of "accountable care" mental health services.

Overarching are identified service delivery systems, driven by the importance of ensuring access for historically underserved populations and employing proven clinical practices, combined with support services. While mental health service providers include clinical therapists, psychiatrists, nurses, and others who have a recognized scope of practice, the mental health system is not an amalgamation of individual practitioners with their own unique practice styles and competencies. Rather, the County system is an evolved and planned system which holds its provider community to adopted quality assurance, clinical care, cultural competency, and fiscal requirements, assuring consumers that services meet high standards for access, quality, and consumer engagement and empowerment, with an emphasis on achieving outcomes that are meaningful to consumers no matter where provided. In response to consumer needs the system has enjoined case managers to ensure linkage to community resources and supports, with the view of improving and sustaining client outcomes. One of the most valuable assets is the employment of peer specialists and

[*] The passage of Proposition 63 (known as the Mental Health Services Act or MHSA) in November 2004, provided the first opportunity in many years for the California Department of Mental Health to provide increased funding, personnel and other resources to support county mental health programs and monitor progress toward statewide goals for children, transition age youth, adults, older adults and families. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system.

parent partners -- those with “lived experience” who engage those most in need, breaking down the barrier of stigma and cultivating relationships which foster access to care.

County Department of Mental Health and Its Role as Overseer of a Qualified, Culturally Competent Network of Providers

This white paper calls for the County Department of Mental Health’s to marshal its comprehensive array of services for children, youth, adults and older adults, to organize a rational network of mental health providers which melds the requirements of federal legislation and those set forth in the Mental Health Services Act. At every step of the conceptualization and roll-out of health care reform in Los Angeles, especially as involves CMS (federal Medicaid and Medicare), public mental health services should be an equity partner.

In its role as overseer of a network of qualified, culturally competent and accountable providers, County Department of Mental Health is called upon to:

- Coordinate the provision of mental health services for public beneficiaries with health services
- Organize and oversee a qualified provider network
- Establish payment methods (for example, case rates and amounts)
- Serve as intermediary with third party payers.

In accordance with its current responsibilities DMH will monitor the constructs of effective care and related costs. This is in keeping with federal health care reform legislation which is designed to incentivize improvements in care while achieving cost constraints over time.

One of the most critical roles to be assumed by DMH is to develop and oversee operations which ensure care coordination with physical health and drug and alcohol services. Thus, functioning as an equity partner with physical health, especially in light of the extent to which mental health disorders disproportionately affect the public beneficiary population, is viewed as a requisite to ensuring the success of local health care reform.

Integration Services Model and Funding

In its role as overseer for public mental health services the County Department of Mental Health should adopt a revised version of the nationally-recognized Four-Quadrant Clinical Integration Services Model[3] for integrating health and behavioral health services in order to respond to the needs of a large and expanding “safety net” mental health system. This model calls for bi-directional care wherein health center services are located in mental health settings and, conversely, mental health services are located in health center settings. This type of care is based on patient/consumer levels of impairment and needs best met by taking into account issues of access and effective integrated care.

Proposed is that the Four-Quadrant Model be augmented with a middle tier of services (color-highlighted on the following page). This added tier warrants special attention, given the large cohort of prospective consumers, many of whom heretofore have been uninsured given financial constraints.

Matrix for Organizing Mental Health Services and Primary Care Services in Los Angeles County to Meet Accountable Care Requirements

Revised Four-Quadrant Clinical Integration Model Which Incorporates Tier for Moderate Mental Health Needs

Tier 1 Mental Health: **High Risk** Physical Health: **Low Risk** • Integration of primary care providers in mental health agencies to create access to more comprehensive medical services • Wellness activities. • Provision of array of specialty mental health and support services including services for co-occurring disorders. • Behavioral Healthcare Home.	**Tier 1** Mental Health: **High Risk** Physical Health: **High Risk** • Integration of primary care providers in mental health agencies to create access to more comprehensive medical services • Wellness activities. • Provision of array of specialty mental health and support services including services for co-occurring disorders. • Behavioral Healthcare Home.
Tier 2 Mental Health: **Moderate Risk** Physical Health: **Low Risk** • DMH mental health providers to provide time-limited, "medium-dose" mental health interventions, as indicated, at health centers or mental health centers (consumer/patient preference). • Engagement of clients in supportive services to improve mental well-being.	**Tier 2** Mental Health: **Moderate Risk** Physical Health: **High Risk** • Integration of DMH mental health providers at health centers to provide "medium-dose" mental health interventions. • Close coordination with health care provider, to ensure treatment compliance and reduce likelihood of needing higher level of mental health care. • Use of educational efforts to help clients alter behaviors in order to improve management of both health and mental health.
Tier 3 Mental Health: **Low Risk** Physical Health: **Low Risk** • Screening for mental health issues and provision of "low dose" mental health interventions by primary care staff. • Healthcare Home. • Access to mental health provider consultation, as needed.	**Tier 3** Mental Health: **Low Risk** Physical Health: **High Risk** • Screening for mental health issues and provision of "low dose" mental health interventions by primary care staff. • Healthcare Home. • Access to mental health provider consultation, as needed.

Behavioral Health (MH/SA) Risk/Complexity ↑ High / Low

Physical Health Risk/Complexity → Low / High

Tier 1 and 2 mental health services – provided by DMH's network of qualified providers
Tier 3 mental health-related services – provided by health center/primary care staff with consultation available from DMH network providers, as indicated.

In concert with the intent of "accountable care", payment reform should be anticipated and supported. There is a need to transform relatively "unmanaged" fee-for-service structures to pre-set payments (for example, case rates*) within mental health. This could take the form of authorized tiers of mental health service, based on the revised Services Integration Model shown on the prior page.

Tier One – Intensive interventions for those who are seriously mentally ill or emotionally disturbed including, but not limited to: foster care children, incarcerated and formerly incarcerated, parolees, homeless, and other public system consumers who demonstrate significant levels of mental health impairment; also patients who are discharged from psychiatric hospitals. Health center staff to be co-located at mental health agencies to create access for "highest needs" mental health consumers, given consumers' connectedness to mental health agencies which provide supportive services and 24/7 crisis response.

Tier Two – Interventions tailored to those who show more moderate levels of impairment evidenced by academic problems, limited or poor peer relationships, poor family cohesion; included would be CalWORKs recipients, those who experience poor disease management (diabetes, cardiovascular, etc.), children/youth at risk for school failure or suspension/ expulsion or at risk for out-of-home placement, returning Iraq/Afghan war veterans with PTSD, adults on general relief, isolated older adults, those who experience ongoing depression, and probationers. DMH network providers to be co-located at health centers to provide "medium dose" services.

Tier Three – Screenings by health providers for depression, anxiety, PTSD, suicide risk, and early childhood social/emotional development; primary care staff to provide Levels 2 and 3 of the evidence-based practice Triple P (Positive Parenting Program*)[4]; provision of culturally competent, educational materials; provision of time-limited, evidence-based and best practices programs like Maternal Wellness Centers; provision of "low-dose", time-limited early intervention services for ADHD, depression, and anxiety; and operation of advice lines.

With the move to case rates or other new forms of payment is the proposed establishment of an "outliers" fund – essentially a risk pool which this white paper recommends be operated by County Department of Mental Health wherein beneficiaries whose costs exceed their assigned case rates, can have their cases reviewed and authorized for "outliers" funding. Over time, data will establish reasonable costs for each tier and define how much risk actually exists, as well as a process to

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* Case rates – for the purposes of this white paper, case rates are defined as an authorized amount of services to cover each level of care (tiers), using historical data initially to set the amount per client. Proposed to help minimize the risk which providers bear due to fixed amounts (other than being paid for each encounter) would be the creation of an "outliers" pool, managed by County DMH, and payable for exceptional cases where costs exceed "customary" care per tier. The benefit of case rates is to discourage unnecessary services and ineffective care while paying for outcomes and cost effectiveness.

* Triple P Model of Parenting and Family Support – This is an evidence-based program which is directed toward prevention and early intervention to parents with children, ages 0-12. "The program's multi-level framework aims to tailor information, advice and professional support to the needs of individual families. It recognizes that parents have differing needs and desires regarding the type, intensity and mode of assistance they may require. Triple P interventions range from the provision of brief information resources such as tip sheets and videos at Level 1, through to brief targeted interventions (for specific behavior problems) offered by primary care practitioners at Levels 2 and 3, to more intensive parent training programs at Level 4 and Level 5 . . . targeting broader family issues such as relationship conflict and parental depression and stress." Levels 4 and 5 services are provided currently by County Department of Mental Health providers on behalf of children who meet medical necessity criteria.

reassess clients whose mental health issues escalate significantly due to a crisis and who require more intensive services than originally planned. The data may just as forthrightly document the need for "step-down" services. This is the kind of data which must be utilized in the public's interest to ensure accountable care.

Mental Health Services Workforce

The Department of Mental Health's workforce is well-trained to serve all three tiers of services – from prevention and early intervention to highly intensive – with the Mental Health Services Act having codified this continuum of care. For purposes of Los Angeles County, the welcome opportunity is how to best coordinate and integrate this robust mental health services system into health care reform inclusive of care-coordination approaches which ensure accountable care. County mental health services are managed via care-coordination plans; thus the Department of Mental Health and its providers have considerable experience in one of ACA's keystone requirements.

County Department of Mental Health providers are well-versed in behavioral interventions, especially the use of cognitive behavioral therapy for treatment of mood, eating, anxiety, personality, and substance abuse disorders. This kind of intervention is equally applicable to the management of chronic diseases including diabetes, cardiovascular, and pulmonary – the kinds of diseases which, left untreated, too often result in high future medical costs including hospitalization.

The existing public mental health system workforce has been the beneficiary of considerable training in concert with requirements of the Mental Health Services Act with an emphasis on effective treatment and service delivery. These services are governed by County-required quality improvement protocols, consumer services plans with measurable outcomes and identified timelines, and documentation of consumer/family-driven decision-making. Because mental health workforce resources are limited across the nation including insufficient numbers of therapists and psychiatrists "in the pipeline", it is incumbent upon decision-makers to effectively utilize current resources and to support the Mental Health Rehabilitation Option under Medi-Cal which augments the workforce with trained mental health services staff who can deliver mental health skill-building and restorative services, and peer specialists and parent partners.

An added opportunity is to use telemedicine when possible. This is a mode wherein video conferencing allows primary care staff to remotely access consultations from psychiatrists and therapists and vice-versa. As the technology has evolved it is also being used for direct patient services. While once considered a services delivery medium for rural and other more isolated settings, given current workforce shortages, combined with the demands for additional mental health services presented by health care reform, telemedicine can create time-sensitive access to high-level mental health staff, especially psychiatrists, and eliminate costly travel time in between sites. To fully utilize telemedicine certain billing constraints must be removed in concert with the roll-out of health care reform.

Mental Health as a Dominant Factor in Achieving Positive Outcomes in Health Care Reform; Related Supporting Data

Mental health services are a critical component of improving overall well-being and reducing public costs. As stated in the Mental Health Services Act:

> "*(c) Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local government. Many people left untreated or with insufficient care see their mental illness worsen. Children left untreated often become unable to learn or participate in a normal school environment. Adults lose their ability to work and be independent; many become homeless and are subject to frequent hospitalizations or jail. State and county governments are forced to pay billions of dollars each year in emergency medical care, long-term nursing home care, unemployment, housing, and law enforcement, including juvenile justice, jail and prison costs."*
>
> *"(e) With effective treatment and support, recovery from mental illness is feasible for most people. The State of California has developed effective models of providing services to children, adults and seniors with serious mental illness. A recent innovative approach, begun under Assembly Bill 34 in 1999, was recognized in 2003 as a model program by the President's Commission on Mental Health. This program combines prevention services with a full range of integrated services to treat the whole person, with the goal of self-sufficiency for those who may have otherwise faced homelessness or dependence on the state for years to come. Other innovations address services to other underserved populations such as traumatized youth and isolated seniors. These successful programs, including prevention, emphasize client-centered, family focused and community-based services that are culturally and linguistically competent and are provided in an integrated services system.*"
> (Mental Health Services Act (2004), § 2, p. 1)

Strikingly, persons with serious mental illness are dying earlier than the general population (average age of death is 53 years).[5] An Oregon study found these individuals faced the highest risk for reduced longevity of those with co-occurring mental health/drug and alcohol abuse disorders, (average age of death is 45.1 years).[6] Of Medicaid beneficiaries with disabilities, 49% have a psychiatric illness.[7]

Among ten dyads (where there are two diagnostic groups), four of these dyads include psychiatric disorders. The highest cost dyad is for psychiatric and cardiovascular at 25% of all those represented in the ten dyads.[7] County Department of Mental Health Innovation grants, awarded via Proposition 63, are largely directed to the piloting of integrated services for these kinds of high-need, high-cost individuals by way of mobile teams and health center/primary care providers housed at mental health sites. Such innovations are examples of bi-directional care as described in "Integration Services Model and Funding" above. The Innovations-funded approaches recognize the importance of outreach and engagement – taking integrated services "to where consumers are." Woven throughout is the use of peer-run and peer-supported services based on the body of evidence which demonstrates the extent to which such services contribute to improved consumer outcomes.

A 2005 NIMH study[8] documented that:

- 50% of lifetime mental illness occurs by age 14 and 75% by age 24.
- Elderly, uninsured, and ethnic minority individuals exhibit the highest unmet need for mental health services
- Up to 45% of those with a mental health disorder have a second mental health disorder with a higher incidence of co-morbidity among those who are seriously mentally ill.

The National Center for Children in Poverty[9] states "One in five children has a diagnosable mental disorder":

- "One in 10 youth has serious mental health problems that are severe enough to impair how they function at home, school, or in the community."
- "The onset of major mental illness may occur as early as 7 to 11 years old."
- "Factors that predict mental health problems can be identified in the early years."

"Children and youth from low-income households are at increased risk for mental health problems":

- "21% of low-income children and youth ages 6 through 17 have mental health problems."
- "57% of those low-income children and youth come from households with incomes at or below the federal poverty level."

"A greater proportion of children and youth in the child welfare and juvenile justice systems have mental health problems than children and youth in the general population":

- "50% of children and youth in the child welfare system have mental health problems"
- "67% to 70% of youth in the juvenile justice system have a diagnosable mental health disorder."

Depression takes a considerable toll on the working years. "Major depression and other depressive disorders affect one in ten U.S. adults each year and are the leading cause of disability in the United States."[10] Data from 2000 assessed the economic toll of depression at $83.1 billion. Up to $51.5 billion was credited to impacts on workplace, including reduced worker productivity and increased absenteeism. Also associated with depression are negative health behaviors including increased heavy drinking, smoking and substance abuse.[11]

"Infants of clinically depressed mothers often withdraw from caregivers, which ultimately affects their language skills, as well as their physical and cognitive development."[12]

For individuals who have diabetes, they face a higher risk for depression compared to the general population – estimated at twice the risk. Within primary care clinics in Los Angeles, diabetes patients are a significant cohort.[13]

PTSD is also highly prevalent and is cross-cutting with depression. NIMH data establishes that one in 30 individuals across the general population will experience symptoms which rise to the level of PTSD in any 12-month period.[14] Shockingly, the incidence in returning Iraqi and Afghan war veterans is estimated at one in five.[15]

The exposure to trauma is especially crippling for very young children – ages 18 to 36 months – where a single event can lead to 35% of those exposed developing serious mental health problems.[16]

"Unlike adults, babies and toddlers have a fairly limited repertoire of responses to stress and trauma. Mental health disorders in infants and toddlers might be reflected in physical symptoms (poor weight gain, slow growth, and constipation), overall delayed development, inconsolable crying, sleep problems, or aggressive or impulsive behavior and paralyzing fears."[17]

Infusing Mental Health Services into Non-Traditional Sites

Mental health providers in Los Angeles have long assumed the initiative in infusing mental health services into settings where children, youth, families and adults with mental health needs congregate – including but not limited to pre-schools and schools, domestic violence shelters, health centers, and subsidized housing sites. Services are also provided in consumers' homes and other community settings preferred by service recipients. Of significance: mental health programs in Los Angeles County have earned national recognition from entities like the American Psychiatric Association, American Academy of Child and Adolescent Psychiatry and Mental Health America for their innovative and culturally competent services which create access for underserved communities and advance outcome-driven results. Thus, this white paper supports the imperative of bi-directional care as cited above in "Integration Services Model and Funding."

Leadership of County Officials

In order to create a re-envisioned health, mental health, and drug and alcohol services system County leadership will need to support a clear vision which places accountable care – centered on improved health and mental health outcomes within reasonable costs – at the forefront. Undergirding the transformation of health services, mental health, and drug and alcohol services must be an integrated patient/consumer electronic record which allows service providers across the spectrum to operate with a single service plan and an identified accountable care coordinator. Built into the architecture of the electronic record must be a set of guiding principles in support of integrated, accountable care. To achieve an integrated record the County should furnish legal and technical resources that can remove the current administrative and fiscal barriers experienced by the three domains (health, mental health and drug and alcohol) and the provider communities. Pooling funds to underwrite the cost of an integrated electronic record system is strongly recommended.

Importantly, decision makers need to influence the reimbursement mechanisms under health care reform in support of a rational system which incentivizes health plans and providers to achieve positive outcomes, not merely deliver discrete episodes of service. For those who have been at the forefront of public health care advances, they can attest to the extent to which payment methods shape the delivery and provision of services. While re-envisioned County health, mental health, and drug and alcohol services hold great potential to deliver improved patient/consumer outcomes, this aspiration will not be realized until payment methods are re-aligned to support accountable care.

Near-Term Recommendations to Support Transition to Integrated Services and To Effectively Use Existing Public Resources

The 1115 Waiver* includes opportunities to incorporate primary care services in mental health agencies on behalf of effectively providing integrated services to persistently mentally ill adults. As cited above in "Integration Services Model and Funding," psychiatric disorders are highly prevalent in high-cost dyads. Untreated or under-treated persistent mental illness negatively impacts one's ability to effectively manage a co-morbid health condition like cardiovascular, diabetes, and pulmonary. Because the Department of Health Services and the Department of Mental Health are county services, the Board of Supervisors can proactively address the issue of effective utilization of resources by way of bi-directional services, especially during these turbulent economic times.

Notable are MHSA Innovation funds which underwrite demonstration projects including mobile units comprised of primary care, mental health, and drug and alcohol services along with peer advocates (cited above). Also funded under MHSA Innovations are specialty projects for historically under-represented ethnic populations which place mental health providers in primary care facilities. These are key examples of bi-directional care where current primary health care and mental health providers cooperatively enjoin their service providers to work at each entities' sites in the best interest of public beneficiaries in need of integrated services.

While the 1115 Waiver and MHSA Innovation projects are important new initiatives, there are several opportunities to support more integrated services involving current health and mental health-funded services. One such opportunity exists where primary care has sited health clinics at school sites. Often there are community-based mental health providers already providing school-based services. Requiring Memoranda of Understanding between primary care and mental health providers to ensure the highest and best use and coordination of existing resources is both a fiscal imperative and a means of effectively addressing health and mental health disparities in high-needs communities.

In addition, publicly-funded health centers are serving children where emotional and/or behavioral problems meet criteria for accessing Medi-Cal/EPSDT entitled mental health services via County Department of Mental Health. At the same time, these health centers are not systematically coordinated with public mental health services. The use of a simple, caregiver-completed screening tool like the Pediatric Symptom checklist[18] or the CiMH Tool[19] can be used to identify children being seen in health centers who should have access to entitled EPSDT mental health benefits. As has been previously stated, existing mental health providers have long advocated for co-locating their services at sites where children and families in need congregate – in preschools and schools, domestic violence shelters, health centers, and other community venues.

An additional recommended near-term initiative is to ensure that positive social/emotional development is infused throughout all First 5 LA programs and projects in a quantifiable way, especially early literary programs. "The emotional, social and behavioral competence of young children is a strong predictor of academic performance in elementary school."[20] Social and emotional development is just as important as literacy, language and number skills in helping young children prepare for school."[21]

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* Section 1115 Waiver – This latest such waiver (2010), incorporates mental health services as a mandated service for the first time. The waiver will convert previously low income uninsured individuals to funded health care. The first roll-out in Los Angeles is called Healthy Way LA on behalf of largely childless adults up to 133% of poverty level.

As for adult services, of great concern is the demand being placed on limited mental health services by returning parolees under AB 109. Today's adult services slots are filled by those who are persistently mentally ill, including formerly incarcerated and homeless individuals, and those who are high users of psychiatric inpatient services. Resources under AB 109 should be earmarked for returning parolees, given their documented disproportionate need for mental health and drug and alcohol services. In an August 19, 2011 Los Angeles Times article,[22] the following statistics were reported regarding California inmates' needs for these services:

> "About 55% of inmates reported a recent history of or symptoms of mental illness. Of those with recent symptoms, 20% reported symptoms of major depression, 42% reported symptoms of mania disorder and 16% reported symptoms of a psychotic disorder. In terms of substance abuse or dependence, 58% of California inmates reported symptoms that met the diagnostic criteria for drug abuse or dependence, and 55% for alcohol abuse or dependence."
> (These data are based on inmate self-reports.)

Clearly returning parolees should be a high priority population for mental health, drug and alcohol services. At the same time, the County must ensure that new policy and/or funding initiatives do not negatively impact current, very high-needs consumers.

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The Second Supervisorial District Empowerment Congress Mental Health Committee sees much hope on the horizon for improving the health and mental health status of some of our County's neediest individuals.

Public beneficiaries experience factors which place them at much higher risk for poor health and mental health outcomes. Integrating care is the touchstone for improving the well-being of countless thousands of county residents. The design of integrated care including the effective use of existing county assets, shared technology, and leadership which is committed to re-envisioning the health, mental health, and drug and alcohol services system will ultimately determine the success of the seminal opportunity presented by health care reform.

Contacts:

Elizabeth W. Pfromm, M.S., MPA
Co-Chair, Empowerment Congress
Mental Health Committee
Los Angeles Child Guidance Clinic
Tel: (323) 766-2360, ext. 3306
Fax: (323) 766-2370
Bpfromm@lacgc.org

Jack Barbour, M.D.
Co-Chair, Empowerment Congress
Mental Health Committee
S.C.H.A.R.P.
Tel: (310) 631-8004
Fax (310) 631-5875
jmbarbour@earthlink.net

ENDNOTES

[1] Patient Protection and Affordable Care Act (2010) (can be viewed in full at http://www.healthcare.gov/law/full/).

[2] Mental Health Services Act (2004)
Mental Health Services Act § 2, p.1 (2004)
(retrieved from http://www.dhcs.ca.gov/services/mh/Pages/MH_Prop63.aspx).

[3] The Four Quadrant Clinical Integration Model, National Council for Community Behavioral Healthcare (2006); Minkoff, K. *Dual Diagnosis: an integrated model for the treatment of people with co-occurring psychiatric and substance disorders in managed care systems*. Presented to National Council for Community Behavioral Healthcare conference, March 2002 (multiple revisions and adaptations have occurred over time).

[4] Triple P-Positive Parenting Program®, Professor Matthew Roy Sanders, et al., Parenting and Family Support Centre, University of Queensland, Australia (website: www.triplep.net).

[5] Morbidity and Mortality in People with Serious Mental Illness. National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, October 2006.

[6] *Measuring Premature Mortality among Oregonians*. Oregon Department of Human Services Addiction and Mental Health Division, June 10, 2008.

[7] R.G. Kronick, M. Bella, T.P. Gilmer. *The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions*. Center for Health Care Strategies, Inc., October 2009.

[8] National Comorbidity Survey-Replication (NCS-R): Kessler RC, Berglund PA, Demler O, Jin R, Walters EE. *Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R)*. Archives of General Psychiatry. 2005 Jun;62(6):593-602.

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