RECOMMENDATIONS FOR THE FY 2004-05 BUDGET FOR LOS ANGELES COUNTY'S DEPARTMENT OF MENTAL HEALTH:

A Report Summarizing the Agreement and Divergence Resulting from the Stakeholder Process

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EXECUTIVE SUMMARY

Los Angeles County's Department of Mental Health (DMH) faces a substantial budget shortfall in the coming budget year. Given the projected size of the shortfall—currently estimated at $30.6 million in Net County Cost (NCC) dollars—and its potential implications for the people who receive mental health services throughout Los Angeles County, DMH organized an expansive stakeholder process to assess how best to address this shortfall.

To date, the stakeholder process has proceeded through two phases. Phase 1 began in early March and continued through mid-April. Well over 500 people participated in Phase 1, including people who currently receive mental health services, families of people receiving services, contract providers, DMH representatives, representatives from other County Departments, law enforcement agencies, hospitals, groups serving particular ethnic populations in the County, and many others. In Phase 2, delegates chosen by the stakeholder groups during Phase 1 met in a series of intensive meetings over a three-week period between late April and early May 2004.

At the beginning of Phase 2, delegates agreed to develop recommendations about how to allocate $187 million in NCC dollars within the DMH budget. This figure is what remains of projected NCC dollars available to DMH for FY 2004-05 after subtracting: NCC dollars necessary to meet matching requirements; NCC dollars necessary for fixed costs; and the projected shortfall.

At the end of Phase 2, delegates from 25 of the 26 stakeholder groups reached agreement on recommendations for $186 million of the available $187 million. The recommended allocations reflect remarkable convergence among the 25 groups, including but not limited to agreement on the following three points.

1. The projected $30.6 million budget shortfall will require a significant redesign of the system of mental health services and supports for people in Los Angeles County, particularly for people who do not have access to insurance or other payer sources.

2. The delegates believe that many of the recommended allocations, and the changing priorities among the allocations, will help the system evolve in ways that, over time, will improve the quality of care for all people served by the system. In particular, the recommended allocations are intended, among other aims, to help the system:
   - accelerate its movement away from institutionalized care toward community-based care, including self-help and other community-based approaches, wherever possible.
   - improve its capacity to establish payer sources as quickly as possible for every child and adult who qualify; and
   - more aggressively pursue savings in medication costs while doing everything possible to insure that people are able to get access to needed medications and the support they require to effectively use those medications.

3. The delegates also know, and want decision-makers and the larger community to understand, that *the reductions in services reflected in the recommended allocations will result in profound suffering throughout the County* as significant numbers of people, many in crisis, will not be able to get the mental health services they need.

The stakeholder groups who participated in this process did not reach consensus on all of the recommendations; significant divergence remains between the Department of Health Services and the other stakeholder groups, and some divergence exists even among the other stakeholder groups.

No one wanted to start a conversation about how to cut another $30 million to $50 million from a budget that has already sustained substantial cuts in recent years. No one wanted to start this conversation in large part because everyone understood, intimately, the impact that further cuts would have on many of the individuals and families who need mental health services in LA County. No matter what decisions are ultimately made, reducing the budget for the County's mental health system by $30 million or more will mean that services will be cut, and people who need those services will not be able to get them.

Once the various stakeholder groups joined this conversation, however, they did so with an abiding commitment first, to minimize the harm done by the funding reductions, and second, to make choices that improve the overall system wherever possible. As difficult as this process has been, all of the groups agree that it has generated far better recommendations than would have emerged had this process not taken place.

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INTRODUCTION

Los Angeles County's Department of Mental Health (DMH) faces a substantial budget shortfall in the coming budget year. Given the projected size of the shortfall—initially estimated at $48.8 million, currently estimated at $30.6 million—and its potential implications for the people who receive mental health services throughout Los Angeles County, DMH organized an expansive stakeholder process to assess how best to address this shortfall.

To date, the stakeholder process has proceeded through two phases. Phase 1 began in early March and continued through mid-April. During this phase, individual stakeholder groups met to:

- review an overview of DMH's budget, including an analysis of the sources of the projected shortfall;
- review a preliminary plan to address the shortfall developed by the Department's Leadership Team;
- develop preliminary proposals to address some or all of the projected shortfall; and
- choose delegates to participate in the second phase of this process.

Well over 500 people participated in Phase 1 of the stakeholder process, including people who currently receive services in the mental health system, families of people receiving services, contract providers, DMH representatives, and representatives from other County Departments, law enforcement agencies, hospitals, groups serving particular ethnic populations in the County, and many others. Attachment 7 lists the groups invited to participate in this process.

Groups began meeting in mid-March. Many continued meeting regularly until the end of Phase 1; twenty submitted worksheets outlining their initial responses to the shortfall, including recommended principles and plan parameters, and in some cases, detailed responses and alternative recommendations to the Leadership Team's initial approach.

In Phase 2, delegates chosen by the stakeholder groups during Phase 1 met in a series of intensive meetings over a three-week period between late April and early May 2004. Attachment 8 lists the delegates and alternates chosen by the stakeholder groups to participate in Phase 2.

The delegates made great progress in reaching agreement about how to structure the FY 2004-05 budget for DMH, and more importantly, how to evolve the system of mental health services in order, at minimum, to mitigate the harm that will result from the projected loss of dollars to the system. This document summarizes both the agreements, and the remaining divergence, among the stakeholder delegates.

THE DOLLARS ADDRESSED BY THE STAKEHOLDER PROCESS

DMH initially projected the FY 2004-05 budget shortfall at $48.8 million; the current estimate is $30.6 million. Attachment 1 details the evolution of this estimate from early January until now.

Summary of recommendations

For Phase 1 of the process, DMH developed a one-page summary of the proposed FY 2004-05 budget submitted to the Chief Administrative Officer (CAO) in early 2004. Table 1 presents this budget summary. For each line item in the budget, the table shows:

- the gross appropriation;
- the amount of the gross appropriation coming from sources other than County General Fund dollars (labeled Revenue/Intrafund); and
- the amount of the gross appropriation coming from the County General Fund (labeled Total Net County Cost (NCC)/Sales Tax);

The summary then takes this total Net County Cost/Sales Tax column and, for each line item, shows:

- Net County Cost/Sales Tax dollars used either for categorical services[1] or for matching requirements[2] (labeled NCC/Sales Tax used for match);
- Net County Cost/Sales Tax dollars required for fixed costs[3]; and finally
- Net County Cost/Sales Tax dollars available for curtailment.

The stakeholders ultimately agreed, for the purposes of the process for FY 2004-05, to focus their attention on this last column. Why? For several reasons. First, DMH pays certain fixed costs associated with services—e.g., leases, retirement benefits—that must be paid regardless of whether services are cut. No help with the shortfall there. Second, any cuts made to categorical services would not address the shortfall, because cuts to these services would result in an immediate loss of the funds used to pay for the services.

Third, cuts made to services funded with matching dollars would similarly result in the loss of the matching dollars. While true that such cuts would free up some County General Fund dollars no longer required for the match, given the time pressures in this year's process and the severity of the projected shortfall, the delegates agreed not to consider curtailments to services funded with matching dollars. The delegates agreed to revisit this issue within a much broader, and more deliberate, examination of funding for the overall system to occur in the coming year.

Once fixed costs and costs associated with categorical services and matching requirements are removed from the Net County Cost/Sale Tax portion of the gross appropriation, what remains to be curtailed is the last column in Table 1. Again, Table 1 reflects the budget DMH submitted to the CAO in early 2004, including the unidentified curtailment projected at that time to be $44.6 million ($44,592,000).

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[1] Funds the Department receives for "categorical" services and programs must be used for a specific purpose or target population, or the payer source (e.g., State government, Federal government, or a third party) will not issue payment. That is, if the Department cuts a categorical service or program, it will lose the funding for this service, and thus make no progress toward reducing the budget shortfall.

[2] Many programs and services the Department provides are funded through a combination of County dollars and matching dollars from another payer source (e.g., State government, Federal government, or a third party). To receive the funds from the third party the County *must* commit some of its own resources.

[3] Note that the fixed costs identified in Table 1 are those fixed costs associated with County directly operated programs only and not to fixed costs incurred by contract agencies.

TABLE 1: OVERVIEW OF PROPOSED FY 2004-05 DMH BUDGET

	Gross Appropriation	Revenue/ Intrafund	Total NCC/Sales Tax	NCC/Sales Tax Used for Match	NCC/Sales Tax Required for Fixed Costs*	NCC/Sales Tax Available for Curtailment
General Mental Health Services	720,094,000	522,260,000	197,834,000	(129,974,000)	(25,670,000)	42,190,000
Medication	39,354,000	120,000	39,234,000			39,234,000
Juvenile Justice	2,332,000	97,000	2,235,000		(204,000)	2,031,000
Forensic Services	26,350,000	608,000	25,742,000		(2,006,000)	23,736,000
Fee for Service	80,632,000	80,632,000				
Institutes for Mental Disease	45,926,000		45,926,000			45,926,000
State Hospital	42,494,000		42,494,000			42,494,000
Department of Health Services	32,013,000	10,000,000	22,013,000	(8,847,000)		13,166,000
Public Guardian	11,995,000	4,507,000	7,488,000	(2,971,000)	(2,470,000)	2,047,000
Administration	69,212,000	21,168,000	48,044,000	(25,903,000)	(15,396,000)	6,745,000
Unidentified Curtailment	(44,592,000)		(44,592,000)			(44,592,000)
Totals	**1,025,810,000**	**639,392,000**	**386,418,000**	**(167,695,000)**	**(45,746,000)**	**172,977,000**

Once delegates agreed to focus on the last column of the budget, an issue arose about the approach to the process: specifically, whether to focus on the amount of dollars that needed to be cut, or on the amount of dollars that needed to be allocated. This is not a trivial distinction. A process that focuses on what line items should be cut starts from the status quo allocations; a process that focuses on where available dollars should be allocated starts with all line items at zero.

The delegates decided the allocation focus would better help them explore not only how to address the shortfall, but more importantly, how to evolve the system to achieve both budget reductions and, where possible, improvements in services and outcomes.

To effectively hold this allocation discussion, however, required that delegates have much greater detail about the budget. In particular, they needed to understand what services and programs were included in the General Mental Health Services line item on the summary budget in Table 1.

Table 2 expands the summary budget to include sub-line items for General Mental Health Services. It also isolates the last column of the previous table: those Net County Cost/Sales Tax Revenues available for curtailment after fixed costs, and funds allocated for matching requirements or categorical services, have been subtracted. Note that the sub-total for General Mental Health Services in Table 2—$42,190,000—is exactly the same amount indicated in the last column for General Mental Health Services in Table 1. All of the other numbers in Table 2 match exactly the last column numbers in Table 1. Please see Attachment 2 for a more detailed description of each sub-line item in Table 2.

So what was the total amount of money the stakeholder delegates addressed? In Table 2, the projected budget shortfall (labeled unidentified curtailment) is shown, just as it was in the projected FY 2004-05 budget, at $44.6 million. That leaves a total of $172,977,000 to be allocated among all of the line items.

As noted previously, however, the current projected shortfall is $30.6 million, or $14 million less than was projected in March 2004 (see Attachment 1). Put differently, current projections are that there will be $14 million more to allocate among the line items above the original calculation of $172,977,000. Table 2 shows these additional dollars, bringing the total Net County Cost/Sales Tax funds projected to be available for FY 2004-05 to $186,977,000. Rounding to the nearest hundred thousand, this puts the **total to be allocated at $187 million.** [4]

[4] Please note that the delegates completed their Phase 2 deliberations on May 7, 2004. The Governor's May Revise budget is scheduled for release later this month, and other developments could affect, either positively or negatively, the final number to be allocated. The delegates have addressed this issue in two ways. Attachments 3, 4, 5, and 6 include individual stakeholder recommendations, some of which address the issue of what to do if more, or less, funds are available for allocation. These recommendations are from individual stakeholder groups and have not yet been discussed by the full group. All of the delegates will meet again on May 26, 2004 to review the implications of the Governor's May Revise and other developments, and will decide at that time whether more discussion about allocations is warranted.

TABLE 2
EXPANDED SUMMARY BUDGET CHART:
THE NET COUNTY COST/SALES TAX REVENUES AVAILABLE FOR CURTAILMENT

SERVICE CATEGORY	NCC/Sales Tax revenues available for curtailment from Proposed FY 2004-05 budget
General Mental Health Services	
Mental Health Services	12,775,000
Crisis Intervention	3,094,000
Residential Care/Interim Assistance	4,000,000
Medication Support	5,651,000
Day Treatment	1,028,000
Self-Help/Consumer	1,500,000
Case Management Brokerage/ Linkage	2,342,000
In-patient Services (non DHS)	7,400,000
Mental Health Promotion	1,900,000
Community Outreach Services	2,500,000
Sub-total General Mental Health	**42,190,000**
Medication	39,234,000
Juvenile Justice Services (services in the juvenile halls and camps)	2,031,000
Forensic Services (services in the jails)	23,736,000
Institutes for Mental Disease (IMDs)	45,926,000
State Hospital	42,494,000
Department of Health Services (DHS)	13,166,000
Public Guardian	2,047,000
Administration	6,745,000
Sub-total non-General Mental Health	**175,379,000**
Original Unidentified Curtailment	(44,592,000)
Total from Proposed FY 2004-05 Budget	**172,977,000**
Additional NCC/Sales Tax funds projected to be available for allocation in FY 2004-05	**14,000,000**
TOTAL NCC/Sales Tax funds projected to be available for allocation in FY 2004-05	**186,977,000**

OVERVIEW OF THE RECOMMENDATIONS

Delegates from 26 stakeholder groups participated in all of the Phase 2 sessions. In the final recommendations, 25 of these groups reached agreement on how to allocate $186 million of the $187 million projected to be available for FY 2004-05, or 99.46% of the available funding. The recommendations from the remaining stakeholder group, the Department of Health Services, diverged significantly from the other 25 groups.

The next sections of this paper outline the agreements reached among 25 of the 26 stakeholder groups, analyze the divergence among these groups, and then summarize the recommendations from the Department of Health Services in relationship to the recommendations from the other 25 groups.

THE AGREEMENT AMONG 25 OF THE 26 GROUPS

Table 3 summarizes the agreement among 25 of the 26 groups about recommended allocations for FY 2004-05. The recommended allocations reflect remarkable convergence among the 25 groups, including but not limited to the following:

1. The projected $30.6 million budget shortfall will require a significant redesign of the system of mental health services and supports for people in Los Angeles County, particularly for people who do not have access to insurance or other alternative payer sources.

2. The delegates believe that many of the recommended allocations, and the changing priorities among the allocations, will help the system evolve in ways that, over time, will improve the quality of care for all people served by the system. In particular, the recommended allocations are intended, among other aims, to help the system:
   - accelerate its movement away from institutionalized care toward community-based care, including self-help and other community-based approaches, wherever possible. The delegates have many concerns about the quality of care offered to people placed in state hospitals and Institutes for Mental Disease (IMDs), and will continue working throughout the coming year to develop recommendations for safely moving more people out of those settings, and improve the care for people who must remain in those settings;
   - improve its capacity to establish alternative payer sources as quickly as possible for every child and adult who qualify for alternative sources of support; and
   - more aggressively pursue savings in medication costs while doing everything possible to insure that people are able to get access to needed medications and the support they require to effectively use those medications.

3. The delegates also know, and want decision-makers and the larger community to understand, that *the reductions in services reflected in the recommended allocations will result in profound suffering throughout the County* as significant numbers of people, many in crisis, will not be able to get the mental health services they need.

TABLE 3: SUMMARY OF AGREEMENT AMONG 25 OF THE 26 STAKEHOLDER GROUPS

Projected Budget Shortfall: $30.6 million (rounded to the nearest hundred thousand)
Projected Amount to Allocate: $187 million (rounded to the nearest hundred thousand)

SERVICE CATEGORY	PROPOSED FY 2004-05 BUDGET	RECOMMENDED FY 2004-05 FUNDING
General Mental Health Services		
Mental Health Services	12.8	11.1
Crisis Intervention	3.1	2.3
Residential Care/Interim Assistance	4.0	3.5
Medication Support	5.7	4.8
Day Treatment	1.0	0.0
Self-Help/Consumer	1.5	2.5
Case Management Brokerage/ Linkage	2.3	2.3
In-patient Services (non DHS)	7.4	4.5
Mental Health Promotion	1.9	0.0
Community Outreach Services	2.5	2.0
Sub-total General Mental Health	**42.2**	**33.0**
Medication	39.2	30.0
Juvenile Justice Services	2.0	3.3
Forensic Services	23.7	23.7
Institutes for Mental Disorders (IMDs)	45.9	41.6
State Hospital	42.5	34.7
Department of Health Services (DHS)	13.2	12.2
Public Guardian	2.1	2.1
Administration	6.8	5.4
Sub-total non-General Mental Health	**175.4**	**153.0**
Unidentified curtailment	(44.6)	0.0
TOTAL	**173.0**	**186.0**

THE DIVERGENCE AMONG 25 OF THE 26 GROUPS: VERSION 1 AND 2 OF THE RECOMMENDATIONS

Note that the total amount recommended in Table 3 is $186 million, not the $187 million projected to be available for FY 2004-05. The groups diverged on a recommended allocation of $1 million. The shaded areas in Table 4 highlight the two different proposals for allocating the $1 million.

The divergence starts with the recommended allocation to the Department of Health Services (DHS). Those groups endorsing Version 1 of the recommendations, including the delegation from the Department of Mental Heath, allocated $13.2 million to DHS instead of $12.2 million as indicated in Table 3.

The amount of dollars DMH should allocate to DHS for services DHS provides has been a long-standing issue between the two Departments. Indeed, staff members from both Departments and the CAO are working to develop an agreed-upon method for calculating this amount in future years. For FY 2004-05, however, DMH leaders believe that, in a series of specially called meetings by the CAO earlier this year, an agreement was struck between leaders from the two Departments and the CAO that, absent an agreed upon formula for calculating what DMH should allocate to DHS, the allocation for FY 2004-05 would be $13.2 million. Relying on representations of this agreement from DMH delegates and the delegate from the CAO, those groups that endorsed Version 1 recommended that the agreed upon amount of $13.2 million be allocated to DHS.

Those groups that endorsed Version 2 expressed concerns about the accessibility and cost-effectiveness of services provided in the public hospitals. These groups chose to recommend an allocation of $12.2 million to DHS instead of the $13.2 million in Version 1, and to allocate the resulting $1 million to in-patient services offered by providers other than DHS.

THE DIVERGENCE BETWEEN THE DEPARTMENT OF HEALTH SERVICES AND THE OTHER 25 GROUPS: VERSION 3 OF THE RECOMMENDATIONS

The divergence documented above foreshadows the more pronounced divergence between DHS and the rest of the stakeholder groups. While the other stakeholder groups chose between allocating $13.2 and $12.2 million to DHS, DHS delegates chose to recommend an allocation of $23.2 million to DHS, or $10 million more than Version 1. Version 3 of the recommendations, therefore, shows a $10 million additional allocation to DHS than in Version 1, and a $10 million reduction to the other line items. The shaded areas in Table 5 highlight the differences between the 3 versions of the recommendations.

TABLE 4: SUMMARY OF DIVERGENCE AMONG 25 OF THE 26 STAKEHOLDER GROUPS

Projected Budget Shortfall: $30.6 million (rounded to the nearest hundred thousand)
Amount to Allocate: $187 million (rounded to the nearest hundred thousand)

SERVICE CATEGORY	Proposed FY 2004-05 Budget	VERSION 1: Recommended FY 2004-05 Funding	VERSION 2: Recommended FY 2004-05 Funding
General Mental Health Services			
Mental Health Services	12.8	11.1	11.1
Crisis Intervention	3.1	2.3	2.3
Residential Care/Interim Assistance	4.0	3.5	3.5
Medication Support	5.7	4.8	4.8
Day Treatment	1.0	0.0	0.0
Self-Help/Consumer	1.5	2.5	2.5
Case Management Brokerage/ Linkage	2.3	2.3	2.3
In-patient Services (non DHS)	7.4	4.5	5.5
Mental Health Promotion	1.9	0.0	0.0
Community Outreach Services	2.5	2.0	2.0
Sub-total General Mental Health	**42.2**	**33.0**	**34.0**
Medication	39.2	30.0	30.0
Juvenile Justice	2.0	3.3	3.3
Forensic Services	23.7	23.7	23.7
Institutes for Mental Disorders	45.9	41.6	41.6
State Hospital	42.5	34.7	34.7
Department of Health Services (DHS)	13.2	13.2	12.2
Public Guardian	2.1	2.1	2.1
Administration	6.8	5.4	5.4
Sub-total non-General Mental Health	**175.4**	**154.0**	**153.0**
Unidentified Curtailment	(44.6)	0.0	0.0
TOTAL	**173.0**	**187.0**	**187.0**

TABLE 5: SUMMARY OF DIVERGENCE BETWEEN DHS AND THE OTHER GROUPS

Projected Budget Shortfall: $30.6 million (rounded to the nearest hundred thousand)
Amount to Allocate: $187 million (rounded to the nearest hundred thousand)

SERVICE CATEGORY	Proposed FY 2004-05 Budget	VERSION 1: Recommended FY 2004-05 Funding	VERSION 2: Recommended FY 2004-05 Funding	VERSION 3: Recommended FY 2004-05 Funding (DHS)
General Mental Health Services				
Mental Health Services	12.8	11.1	11.1	8.6
Crisis Intervention	3.1	2.3	2.3	2.5
Residential Care/Interim Assistance	4.0	3.5	3.5	3.0
Medication Support	5.7	4.8	4.8	3.3
Day Treatment	1.0	0.0	0.0	0.0
Self-Help/Consumer	1.5	2.5	2.5	0.5
Case Management Brokerage/Linkage	2.3	2.3	2.3	1.9
In-patient Services (non-DHS)	7.4	4.5	5.5	5.2
Mental Health Promotion	1.9	0.0	0.0	0.0
Community Outreach Services	2.5	2.0	2.0	0.5
Sub-total General Mental Health	**42.2**	**33.0**	**34.0**	**25.5**
Medication	39.2	30.0	30.0	29.0
Juvenile Justice	2.0	3.3	3.3	3.3
Forensic Services	23.7	23.7	23.7	22.9
Institutes for Mental Disorders	45.9	41.6	41.6	41.6
State Hospital	42.5	34.7	34.7	34.7
Department of Health Services (DHS)	13.2	13.2	12.2	23.2
Public Guardian	2.1	2.1	2.1	2.0
Administration	6.8	5.4	5.4	4.8
Sub-total non-General Mental Health	**175.4**	**154.0**	**153.0**	**161.5**
Unidentified Curtailment	(44.6)	0.0	0.0	0.0
TOTAL	**173.0**	**187.0**	**187.0**	**187.0**

The DHS representatives, perhaps not surprisingly, started from a very different perspective than other groups. From their vantage point, the public hospitals are dramatically under funded, and require substantially more funding than even the $23.2 million they are recommending. Moreover, they believe that the cuts to other parts of the mental health system will likely increase the burden faced by the public hospitals in the coming year, and the suffering of people who will need but may not be able to receive mental health services at these hospitals.

For these reasons, DHS representatives opted to recommend an allocation to DHS substantially higher than considered by the other groups. While the DHS representatives do not necessarily diverge from the other stakeholder groups at the level of philosophy, once they decided to recommend a significantly higher allocation to DHS, simple math dictated that they allocate far fewer dollars to virtually every other line item than did the other groups.

NEXT STEPS

Delegates from the various stakeholder groups will meet later in May to consider the implications of the Governor's May Revise budget, and other developments that may also affect the pool of dollars available for FY 2004-05. In a later conversation, they will also review the process to date and consider improvements for subsequent budget cycles. In the meantime, even as they await the final decision from the Board of Supervisors about the FY 2004-05 budget, delegates and others have organized into various workgroups to address short- and long-term implementation issues that will arise because of the system changes necessitated by the projected budget shortfall.

CONCLUSION

The stakeholder groups who participated in this process did not reach consensus on all of the recommendations; significant divergence remains between DHS and the other stakeholder groups, and some divergence exists even among the other stakeholder groups.

No one wanted to start a conversation about how to cut another $30 million to $50 million from a budget that has already sustained substantial cuts in recent years. No one wanted to start this conversation in large part because everyone understood, intimately, the impact that further cuts would have on many of the individuals and families who need mental health services in LA County. No matter what decisions are ultimately made, reducing the budget for the County's mental health system by $30 million or more will mean that services will be cut, and people who need those services will not be able to get them.

Once the various stakeholder groups joined this conversation, however, they did so with an abiding commitment first, to minimize the harm done by the funding reductions, and second, to make choices that improve the overall system wherever possible. As difficult as this process has been, all of the groups agree that it has generated far better recommendations than would have emerged had this process not taken place.

ATTACHMENTS

ATTACHMENT 1:
THE PROJECTED SHORTFALL IN THE DEPARTMENT OF MENTAL HEALTH'S FY 2004-05 BUDGET

The Department of Mental Health (DMH) initially estimated the shortfall for FY 2004-05 at $48.8 million, resulting mostly from losses in one-time revenue available for FY 2003-04. The sources of this initial estimate included:

- *One-Time Prior Year EPSDT Revenue:* This reflects the loss of one-time funding that was used in the 2003-04 Budget to mitigate curtailments. Estimated amount: $32.9 million.

- *1115 Waiver Revenue Reduction:* This reflects the scheduled 2004-05 decrease in our share of federal revenue for the 1115 Waiver Project. Estimated amount: $7.8 million.

- *One-Time Sales Tax:* This reflects the loss of one-time funding from an unanticipated increase in Sales Tax Realignment that was used in the 2003-04 Budget to mitigate curtailments. Estimated amount: $4.7 million.

- *Reduction in Federal Funding Ratio:* This reflects the expiration of the Federal Temporary State Relief legislation that temporarily increased the Federal Medicaid Assistance Percentage beyond the standard 50 percent. Estimated amount: $3.4 million.

Subsequent to the calculation of this initial estimate, the Department learned that the Chief Administrative Office (CAO) would be recommending no increase in the Department's contributions for retirement costs in FY 2004-05. This reduced the projected budget shortfall from $48.8 million to $44.6 million, the figure that is identified in the Department's current proposed FY 2004-05 budget as "unspecified service reductions." DMH chose to conduct a stakeholder process to help the Department build consensus among its many partners about how to address this shortfall.

Subsequent to the development of the proposed FY 2004-05 budget, DMH identified a number of possible, but by no means certain, mitigations to the shortfall.

1. *On-going revenue*
   a. Children's System of Care (CSOC) "restructuring." Current negotiations at the State level indicate that the elimination of the CSOC program proposed in the January Governor's Proposed 2004-05 Budget will not occur in 2004-05.[5] When the proposed elimination was announced in January, DMH began making plans to absorb the loss of funding using County General Fund dollars. Assuming these cuts do not occur, DMH believes it will be able to restructure agreements with its CSOC partners, including the Department of

[5] The Governor's May Revise budget, released on Friday, May 14, still indicates the elimination of the CSOC funding. DMH will, of course budget for CSOC services within the available funding, and still expects to be able to achieve net savings.

Children and Family Services and others, to free up additional County General Fund dollars.

b. Billing in Juvenile Justice Facilities: DMH has been pursuing negotiations with the State Department of Mental Health around the interpretation of the regulations governing billing for services in juvenile justice facilities. If the Department succeeds in these negotiations, it will be able to bill the State for services DMH already provides in juvenile justice facilities.

c. Revenues from Medi-Cal Certification of ACCESS: DMH expects to secure, sometime before the end of this fiscal year, Medi-Cal certification for ACCESS, the system of providing telephone support services to clients already receiving DMH services. Such certification will allow the Department to bill Medi-Cal for services it already provides.

2. *One-time funding*
   a. SB 90/AB 3632 funding: The State of California owes Los Angeles County approximately $70 million in SB 90 deferred claims for AB 3632 services. Of this amount, about $33 million is owed to the DMH budget (the balance of $37 million is payable to the General Fund). Negotiations are underway in Sacramento to designate a date certain by which these monies (as well as all other SB 90 claims) would be paid to the County. If these negotiations are successful, there may be a way to make a portion of the monies due available in the coming budget year to mitigate the curtailment.

   b. Juvenile Justice federal and State Medi-Cal funds: In FY 2003-04, State personnel raised an issue concerning the appropriateness of certain DMH Medi-Cal billings and reimbursements for services rendered at the juvenile justice facilities. A total of $3.6 million, consisting of $2.0 million in Federal Financial Participation Funds (FFP) and $1.6 million in State EPSDT General Funds, was involved. The $3.6 million was reclassified from revenue because of pending repayment to the State. The Department now believes that it will receive a favorable outcome on our efforts to secure a re-interpretation of the regulations that have resulted in the disallowance of these funds. Given the severity of the projected shortfall, and the likelihood that DMH will prevail with the State and the federal Centers for Medicaid and Medicare Services in allowing the $3.6 million as Medi-Cal reimbursement, DMH will be working with the Auditor-Controller and the CAO to determine whether it can record the $3.6 million as revenues for use in other ways in our FY 2004-05 budget.

   c. Projected rollover funds for both the Children's System of Care and Adult's System of Care.

While no one can predict with certainty the realization of any of these possible mitigations, DMH believes the likelihood is high that at least *some* of these mitigations will be realized. For the initial conversations in Phase 2, therefore, delegates focused on a range of scenarios projecting different levels of the shortfall, from a high of $40.6 million to a low of $10.6 million. At the time of the conclusion of the Phase 2 process—May 7, 2004—delegates agreed that the most likely scenario was one where the budget shortfall was $30.6 million, leaving a balance of

$187 million in County General Funds to be allocated. These were the figures that formed the basis of Versions 1, 2, and 3 of the recommendations.

The delegates from the Stakeholder groups will reconvene on Wednesday, May 26 to examine their recommendations in light of the Governor's May Revise budget and up-to-date information about the possible mitigations. If the numbers vary substantially from the scenario considered by the delegates, they will work to reach consensus on a set of recommendations that reflect the new reality.

ATTACHMENT 2:
EXPLANATIONS OF SUB-LINE ITEMS FOR GENERAL MENTAL HEALTH SERVICES

The sources for the following definitions include: LAC-DMH Guide to Community Mental Health Rehabilitation Service Activity Codes for Clinic Service Providers, March 2002; DMH Policy, Clinical Operations, Service Delivery Definition Policy, effective 10/15/02.

I. MENTAL HEALTH SERVICES are individual or group therapies and interventions designed to provide reduction in mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency. Service activities include:

A. Individual Therapy – Therapeutic interventions, including family therapy and EPSDT substance abuse treatment, for an individual client by an appropriately trained clinician. The intervention is consistent with the client's goals/desired results identified in the Service Plan and focuses primarily on symptom reduction as a means to improve functional impairments.

B. Individual Rehabilitation (Not Psychotherapy) - Assistance in restoring or maintaining a client's functional skills, ADL (Activities of Daily Living) skills, or social skills. Services include medication compliance and support resources, counseling to the client or family, training in leisure activities, substance abuse intervention and case management activities beyond facilitating access to services (i.e. benefits establishment).

C. Collateral - Face to face, field or telephone contact with one or more family member or a significant support person involved in the life of the client, including foster care parents. Services include, but are not limited to, consultation to assist in the better utilization of services, planning and implementing service plans, increasing understanding of the client's condition and counseling for the benefit of the client.

D. Group Therapy – Therapeutic interventions, consistent with the client's goals/desired results, delivered in a group setting and claimed to two or more clients. Includes, but is not limited to, support groups, family groups, insight-oriented and psychotherapeutic process groups.

E. Group Rehabilitation (Not Psychotherapy) – Assistance in restoring or maintaining a client's functional skills, or ADL skills where more than one client is represented. Services include medication compliance and support resources, counseling of the client or family, training in leisure activities.

F. Psychological Testing/Diagnostic Services – Established testing for the psychodiagnostic assessment of personality, development assessment and cognitive functioning. Requires face-to-face contact.

G. **Psychological Testing/Diagnostic Services (Case Activity No Client or Collateral Contact) –** Activities related to psychodiagnostic assessment such as scoring and interpreting tests, and writing psychological testing reports in the absence of a face-to-face or phone contact.

H. **Case Consultation -** Includes time spent with inter/intra-agency (includes Board and Care) staff to discuss clinical and/or other information to enhance a specific client's diagnosis and treatment plan.

I. **Therapeutic Behavioral Services (TBS) -** One-on-one services provided in the home, community or school to children up to the age of 21 who meet certain "class" criteria. TBS services must be part of a service plan that includes other mental health services.

II. CRISIS INTERVENTION SERVICES – Includes a service, lasting less than 24 hours, provided to, or on behalf of, a client for a condition that requires more timely response than a regularly scheduled visit. Crisis Intervention services are limited to addressing the presenting emergency.

III. RESIDENTIAL TREATMENT and **INTERIM ASSISTANCE**

A. **Residential Treatment** includes the following services:

1. **Crisis Residential -**Therapeutic and/or rehabilitation services provided in a 24-hour residential treatment program, as an alternative to hospitalization for individuals experiencing an acute psychiatric episode or crisis, who do not present medical complications requiring nursing care.
2. **Adult Residential -** Rehabilitation services provided in a non-institutional residential setting where Individuals are supported in their efforts to restore, maintain and apply interpersonal and independent living skills, and community support systems.
3. **Transitional Residential -** programs are designated to provide a therapeutic residential community including a range of social rehabilitation activities and services for individuals who are at risk of other institutional placement.
4. **Long-Term Residential** – programs are designed to serve chronically mentally ill individuals who have the potential for improving their emotional, social and vocational functioning. Individuals must be able to benefit from the treatment program with the goal of moving to a less intensive level of care (e.g. community care facilities, semi-independent living and independent living).
5. **Semi-Independent Living –** assisted independent living includes those programs that provide service to clients who are living in apartments or homes owned, leased or rented by the client. Cooperative Housing programs include those programs where the units are owned, leased or rented by the agency providing the service.

B. **Interim Assistance** – Provides board and care funding for clients who are in the process of applying for SSI. In theory, interim assistance funding should be reimbursed to DMH once a client becomes eligible for SSI.

IV. MEDICATION SUPPORT – Services include prescribing, administering, dispensing, and monitoring of psychiatric medication(s) or biologicals necessary to alleviate the symptoms of mental illness, which are provided by a staff person within the scope of practice of his/her profession.

V. DAY TREATMENT SERVICES includes the following services:

A. **Day Treatment Intensive, Half Day -** An organized and structured multi-disciplinary, 3-4 hour, daily treatment program designed as: 1) an alternative to hospitalization or placement in a more restrictive setting or 2) to maintain the client in a community setting or out-of-home placement.

B. **Day Treatment Intensive, Full Day –** Same as Day Treatment Half Day, but the length of the program exceeds 4 hours each day.

C. **Day Rehabilitative, Half Day –** An organized, structured, 3-4 hour, daily program providing evaluation, rehabilitation and therapy to restore or maintain personal independence and functioning consistent with requirements for learning and development.

D. **Day Rehabilitative, Full Day -** Same as Day Rehabilitative, Half Day, but the length of the programs exceeds 4 hours each day.

VI. SELF-HELP/CONSUMER – Consumer run and peer-to-peer support groups and activities.

VII. CASE MANAGEMENT BROKERAGE/LINKAGE includes the following:

A. **Targeted Case Management -** Client or Collateral Contact: an activity assisting one or more client to access medical, educational, social, prevocational, vocational, rehabilitative and other community services; or providing assistance with securing appropriate living arrangements; or consultation in an effort to determine the need for, or access to, any of these services.

B. **Targeted Case Management –** Case Activity (No Client or Collateral Contact): a Targeted Case Management activity provided on behalf of a client in the absence of the client or collateral, such as completing forms, preparing reports, or intra/inter-agency consultations or conferences related to linking a client to services. Includes re-authorization of FFS clients if a case is open.

C. **Benefits Establishment activities:** For the purposes of the Phase 2 process, delegates agreed that money allocated for Benefits Establishment activities, including efforts to establish payer sources for the uninsured, would appear within this sub-line item.

VIII. INPATIENT acute psychiatric inpatient hospital services (24 hour) are provided by a hospital to a client (beneficiary) for whom the facilities, services and equipment are medically necessary for diagnosis or treatment of a mental disorder.

IX. Mental Health Promotion – Includes consultation, education, information, media, community organization, outreach and/or program development that promotes mental health in the community. Such activities are not related to open cases.

X. COMMUNITY OUTREACH SERVICES includes the community client consultation, education, information, community organization, outreach, and/or program development to expand services in the community, as well as any responses to critical incidences and disasters in the community.

ATTACHMENT 3:
COMMENTS FROM STAKEHOLDER GROUPS ENDORSING VERSION 1 OF THE RECOMMENDATIONS

Groups endorsing Version 1 of the recommendations include:

- Academic Partnerships
- Chief Administrative Office
- The Client Coalition
- Comprehensive Community Care Steering Committee
- Department of Children and Family Services
- Department of Mental Health
- Department of Public Social Services
- Mental Health Commission
- National Alliance for the Mentally Ill
- Probation Department
- Service Area Advisory Committee 1
- Service Area Advisory Committee 6

Individual stakeholder groups were given the opportunity, but not required, to offer additional reflections about: the recommendations they endorsed and why; how to address a larger budget shortfall than the currently projected $30.6 million; how to address a smaller budget shortfall than the currently projected $30.6 million; and any additional issues they wanted to address. What follows are the reflections offered by some, though not all, of the groups endorsing Version 1 of the recommendations.

1. **Department of Children and Family Services; Department of Public Social Services; Probation Department**
   a. **Analysis of our overall approach to the funding recommendations:** Our three departments collaborated during the process and reached consensus among us for each of the recommendations even though we each had separate votes as separate delegations.
   b. **Analysis of particular funding recommendations:** Our delegations supported Version 1 which allocated $13.2 million to DHS. The analysis of this recommendation is stated appropriately in the body of the report under the section entitled "The divergence among 25 of the 26 groups" relating to the agreement between CAO, DHS and DMH. We support funding DHS at the agreed upon level.

2. **National Association for the Mentally Ill (NAMI)**
   a. **Analysis of our overall approach to the funding recommendations:** Appreciated that it was inclusive with diverse groups giving their opinions, asking good and sometimes repetitive questions. Time allotment was well supervised. Follow up for volunteer sub committees as needed were scheduled immediately. Approach with action indicated commitment to have all aspects explored by stakeholders.
   b. **Analysis of particular funding recommendations:** I supported Version l because it gave priority to community-based treatment that is both humane and cost effective with evidence-based programs and can provide "hospital care without walls" when properly planned and adequately funded.

c. **Recommendations for how to allocate additional dollars if the budget shortfall is less than $30.6 million:** Priority to residential care/interim assistance.
d. **Recommendations for where to make cuts if budget shortfall exceeds $30.6 million:** At this time I believe a rabbit is bringing the 3632 so I don't believe that will happen.
e. **Additional issues or reflections:** Consultant John Ott did a great job facilitating this Stakeholders Coalition of the Caring. Everyone was received, every opinion considered. The DMH Director and Staff provided answers to every question asked. That was tremendous. I've served on and observed many budget deliberations, but none have been as open and in as much depth, through Q&A as these sessions. Kudos to our leaders!

3. **SAAC 1**

The focus in the Stakeholder Meetings was to move away from institutionalized care toward community-based care, including self-help and other community based approaches. If this does happen, the funds to mental health services, PMRT, housing alternatives, and self-help consumer groups (to list a few) would need to be increased to allow for the development of adequate programs within the community. If this shift in focus happens without adequate planning the results could be disastrous. In the meetings we basically all agreed that our institutions might not be the best alternative for quality care; however, quality of care will be compromised if time for program development and dollars are not allocated for this shift in focus.

The dollars that were shifted from institutions to mental health services will allow for continued, limited services to the uninsured. Therefore, additional dollars will need to be appropriated to develop community-based programs.

Service Area 1 is concerned about the negative consequences of not being prepared to manage the intensive services that are required when an individual is discharged from the State Hospital or IMD. Adequate resources do not exist to manage the acutely ill population. This will then become a dangerous situation for both the consumer and the community.

If additional dollars are obtained, community based services need to be developed to address this focus away from institutionalized care.

If there are more cuts in the budget, it will make it more difficult to service the uninsured in any setting. Perhaps we need to look to other counties or states to see how they manage the uninsured population.

4. **SAAC 6**

The Service Area 6 Stakeholders feel very strongly that mental health services are essential to stabilizing clients and maintaining community living. It is also felt that many services e.g. case management linkage and crisis intervention can be billed as mental health services. Additionally, medication is seen as a service crucial to stabilization.

ATTACHMENT 4:
COMMENTS FROM STAKEHOLDER GROUPS ENDORSING VERSION 2 OF THE RECOMMENDATIONS

Groups endorsing Version 2 of the recommendations included:

- Client Stakeholders' Group
- Law Enforcement, including the Sheriff's Department, Los Angeles Police Department, Long Beach Police Department, Pasadena Police Department, and the Los Angeles Police Chiefs' Association
- Latino Mental Health Council (LatCo)
- Asian Pacific Policy and Planning Council
- Association of Community Human Service Agencies
- Hospitals, including the Short-Doyle hospitals and the Hospital Association of Southern California
- Housing and Homeless Coalition
- Service Area Advisory Committee 2
- Service Area Advisory Committee 3
- Service Area Advisory Committee 4
- Service Area Advisory Committee 5
- Service Area Advisory Committee 7
- Service Area Advisory Committee 8

Individual stakeholder groups were given the opportunity, but not required, to offer additional reflections about: the recommendations they endorsed and why; how to address a larger budget shortfall than the currently projected $30.6 million; how to address a smaller budget shortfall than the currently projected $30.6 million; and any additional issues they wanted to address. Groups endorsing Version 2 of the recommendations developed a joint statement detailing the rationale behind their recommendations. In addition, several of the Version 2 groups offered individual reflections. The joint statement is provided first, followed by the additional reflections from individual groups.

1. Joint statement approved by Stakeholder groups[6] endorsing Version 2

Summary of Position [This covers both Parts II and III of the recommendations.]
The stakeholders groups on the attached list support Version 2 of the DMH stakeholders' process. This version is in all respects the same as Version 1, with the exception of two modifications -- a reduction of $1 million allocated to DHS, which is then shifted to minimize the proposed curtailment to community inpatient programs. Simply put, the stakeholders groups supporting Version 2 believe that the expenditure of funds on current community inpatient programs is a better, more cost-effective expenditure of the mental health system's very limited impatient dollars than the very costly DHS beds, for which availability is often in question.
Given the severity of the Department's budget deficit situation and the great difficulty of the task facing the community stakeholders, we believe that the process itself was an extremely

[6] A personal emergency prevented the SAAC 7 delegate from participating in the process to draft this statement. SAAC 7, therefore, expresses no opinion on the statement, but does endorse Version 2 of the recommendations.

collaborative one, with a great degree of overall consensus on the direction that needs to be taken by the Department.

The past two years have already been very difficult ones for persons with mental illness in this county, primarily those who are uninsured. Community outpatient programs have been asked to absorb almost $10 million in reductions over that period of time. Simply stated, the County's community-based service delivery system today is unable to handle the needs of all of its uninsured clients with serious mental illness -- the County's financial resources are simply inadequate.

Given this reality, it is clear that the community-based outpatient portion of the County mental health system cannot absorb any additional curtailments for those individuals who are uninsured. Fortunately, this has been recognized by the members of Version 2 of the community stakeholders process, who have made it their highest priority to preserve these services, to the greatest degree possible.

Of course, with a projected budget shortfall now exceeding $30 million, painful reductions must be made in other areas, including the state hospitals and IMDs. But difficult decisions had to be made and we believe that Version 2 protects those services that are most cost-efficient as well as most cost-effective. In addition, Version 2 recognizes the incredible importance and effectiveness of client self-help groups in the community mental health system. The stakeholders groups supporting Version 2 believe strongly that additional resources must be made available to expand these self-help programs, which will be critical in assisting clients to transition out of the state hospitals and IMDs, consistent with the Supreme Court's Olmstead decision.

Recommendation Re: Allocation of Additional Dollars

The Version 2 stakeholders groups support additional funding to restore proposed reductions in the areas of medication support, community residential care, short-term community inpatient care, and community outreach services (which are critical to improve access for underserved communities). The Version 2 stakeholders groups also support additional funding for enhanced client self-help programs.

Recommendation Re: Areas for Additional Reductions if Necessary

As painful as additional reductions would be, the Version 2 stakeholders group would propose that any further curtailments necessary come from DMH administration and DHS.

Concluding Reflections

In conclusion, the Version 2 stakeholders groups would like to emphasize that costs for uninsured individuals with serious mental illness in this County will be absorbed somewhere in the County system. The real question is where these costs will be absorbed. We believe that these individuals should be treated in outpatient care and receive the benefits of self-help programs within the mental health system, so that they don't end up in more costly and clearly less appropriate locations for them, such as the County jails, County hospitals, or criminal justice system.

2. **Asian Pacific Policy & Planning Council (A3PCON)**

a. **Analysis of our overall approach to the funding recommendations**

A3PCON's overall approach is articulated in A3PCON's Workgroup Paper submitted to John Ott at the beginning of the Stakeholder Phase II process. As a coalition representing the mental health needs of the underserved, diverse Asian Pacific Islander American (APIA) residents of L.A. County with 20 years of experience in advocacy and program development, A3PCON's approach has always been based on the following principles:

- equity
- access
- cultural competent system of care
- community-based services
- cost-effectiveness
- quality of care
- outcomes

b. **Analysis of particular funding recommendations**

Based on the principles stated above, A3PCON supports Version 2 from the Stakeholder's Group. Version 2 supports community based outpatient, residential and inpatient levels of care. It supports a critical component of a culturally competent system of care, "Community Outreach Services" (COS), to engage individuals and families from underserved communities who generally have a great deal of stigma about receiving mental health services. COS is critical to improve access of underserved groups. In addition, Version 2 supports the system's capacity to establish benefits and alternative payor sources for eligible indigent clients and the pursuit of savings in soaring medication costs. There is also an increase in allocations for self-help/peer to peer support, which A3PCON definitely supports.

c. **Recommendations for how to allocate additional dollars if the budget shortfall is less than $30.6 million**

A3PCON supports additional funding to restore proposed reductions in the areas of medication support, community residential care, and short-term community inpatient care. A3PCON further supports additional funding for community based COS and outpatient care to enhance services to underserved populations so as to improve the current disparities of utilization by ethnic minority populations. A3PCON also supports additional funding to enhance consumer self-help programs.

d. **Recommendations for where to make cuts if budget shortfall exceeds $30.6 million**

As painful as additional reductions would be, A3PCON proposes that any further curtailments necessary come from DMH administration and DHS.

e. **Additional issues or reflections**

One of the major guiding principles developed by the leadership group in the Stakeholder Process is "ensure that, at minimum, changes in the system do not increase disparities in services to underserved demographic populations with equivalent mental health needs."

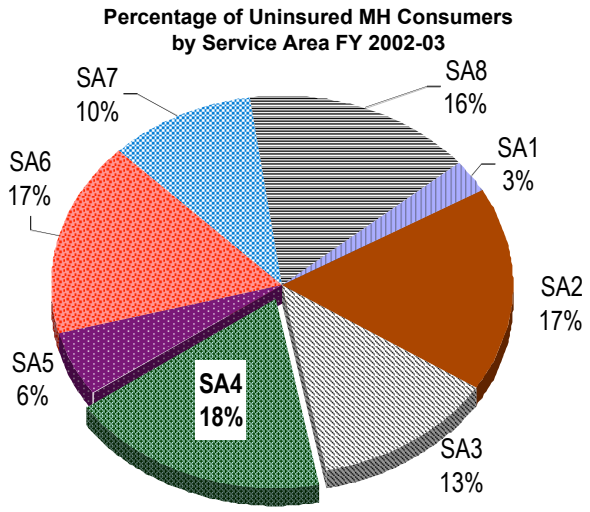
In the latest utilization data distributed by the Department of Mental Health, APIAs represent over 12% of the Los Angeles County general population and 10% of the total Medi-Cal eligible population. However, utilization rates for APIAs in the mental health system continues to lag far

behind parity at 5% of all clients served. It is therefore critical that the community-based system of care for APIAs and other underserved populations be preserved and increased as resources become available.

3. **Hospitals, including the Short-Doyle hospitals and the Hospital Association of Southern California**
   a. **Analysis of our overall approach to the funding recommendations:** We endorse Version 2 that increases revenue for Inpatient Hospitals.
   b. **Analysis of our decisions between the different scenarios:** It becomes a difficult process to decrease Inpatient utilization to the degree proposed.
   c. **Analysis of particular funding recommendations:** This group takes the same position as ACHSA in support of Version 2 of the Stakeholder Process.
   d. **Additional issues or reflections:** As Inpatient providers of services we are concerned that the decrease in bed utilization and decreases in IMD and State beds will pose a burden on each Service Area.

4. **Service Area Advisory Committee 4**

Service Area 4 providers served the largest number of uninsured mental health consumers among the eight mental health service areas in FY 2002-03 (See Chart) This Service Area is the home to numerous immigrant and disenfranchised families and persons who may not be eligible for public assistance or health benefits. SAAC 4 members believe that there is a moral and ethical mandate to serve the uninsured and that funding be preserved for this population. SAAC 4 supports the Version 2 Funding Recommendations for Fiscal Year 2004-05. However, due to the large number of uninsured consumers served in this area (see chart), stakeholders are concerned that funding cuts will have a severe impact on Service Area 4 residents.



SAAC 4 stakeholders have the following concerns and recommendations:

- The proposed plan to reduce State Hospital and IMD resources will significantly impact community based residential resources, including Crisis Residential services. It is recommended that residential resources should not be reduced.

- Community Outreach Services namely community client services, to special populations and underserved communities should be protected. These programs provide essential community based interventions, in some cases the only mental health service, to underserved and high risk populations, e.g., HIV, recently immigrated and emerging ethnic minority groups, runaway youth, and homeless families and individuals.
- The proposed reductions to uninsured acute hospital beds at Gateways Community Mental Health Center will have a significant impact on service area residents as well as other county residents who do not have a payer source. SAAC 4 recommends that funding for these beds not be eliminated.
- SAAC 4 stakeholders recommend that DMH "categorize" the funding for the uninsured. "Categorizing" funding will dedicate dollars for serving the uninsured and for specialty services.
- Service parameters should be established for effective, efficient and high quality services for all programs, regardless of funding or payer source. These parameters should consider the diversity within each geographic area and the cultural and linguistic needs of the communities being served.

5. **Service Area Advisory Committee 5**
   a. **Analysis of our overall approach to the funding recommendations:** *I really appreciate the stakeholder process as an approach to funding recommendations.* It was respectful and inclusive. It enhanced the shared knowledge and analysis of how to create a system with fewer resources to be as effective and responsive as possible. The facilitation that led to phenomenal agreement was excellent.
   b. **Analysis of particular funding recommendations:** See Version 2 recommendations and joint statement above.
   c. **Recommendations for how to allocate additional dollars if the budget shortfall is less than $30.6 million:** See Version 2 recommendations and joint statement above.
   d. **Recommendations for where to make cuts if budget shortfall exceeds $30.6 million:** See Version 2 recommendations and joint statement above.

ATTACHMENT 5:
COMMENTS FROM STAKEHOLDER GROUPS ENDORSING A MODIFIED VERSION 2

United American Indian Involvement, Inc. (UAII) participated in Phase 1 of the process, and the first 4 sessions of Phase 2. They were unable to attend the final 3 sessions of Phase 2. This group submitted an individual worksheet detailing their recommendations. In essence, they endorse Version 2 of the recommendations with a slight modification as indicated below.

1. **Chart detailing UAII's recommendations**

SERVICE CATEGORY	Original FY 2004-05 Projected Budget	Version 2 of the recommendations	UAII recommendations
General Mental Health Services			
Mental Health Services	12.8	11.1	11.1
Crisis Intervention	3.1	2.3	2.3
Residential Care/Interim assistance	4.0	3.5	3.5
Medication Support	5.7	4.8	4.8
Day Treatment	1.0	0.0	0.0
Self-Help/Consumer	1.5	2.5	2.5
Case Management Brokerage/ Linkage	2.3	2.3	2.3
Inpatient	7.4	5.5	5.0
MH Promotion	1.9	0.0	0.0
Community Outreach Services	2.5	2.0	2.5
Sub-total General Mental Health	**42.2**	**34.0**	**34.0**
Medication	39.2	30.0	30.0
Juvenile Justice	2.0	3.3	3.3
Forensic Services	23.7	23.7	23.7
Institutes for Mental Disorders	45.9	41.6	41.6
State Hospital	42.5	34.7	34.7
DHS	13.2	12.2	12.2
Public Guardian	2.1	2.1	2.1
Administration	6.8	5.4	5.4
Sub-total non-General Mental Health	**175.4**	**153.0**	**153.0**
Unidentified curtailment	(44.6)	0.0	0.0
TOTAL	**173.0**	**187.0**	**187.0**

2. **Comments:** We are in general agreement with Version 2 of the recommendations. We have reduced the allocation to In-patient services by $500,000 from the recommendation in Version 2, however, and allocated this $500,000 to Community Outreach Services. We added to the community outreach services particularly for the American Indian community due to the disparities that exist for our community. This funding is necessary to increase access to the American Indian community, which is severely underserved and historically has been underserved by the LA County DMH system.

ATTACHMENT 6:
COMMENTS FROM THE DEPARTMENT OF HEALTH SERVICES ABOUT VERSION 3 OF THE RECOMMENDATIONS

As noted in the narrative, the Department of Health Services (DHS) diverged significantly[7] from the other stakeholder groups, developing a Version 3 of the recommendations.

What follows are additional reflections from DHS detailing the rationale behind their recommendations. The reflections are organized into 3 scenarios. **Scenario 1 assumes a $40.6 million budget shortfall,** therefore requiring a $10 million reduction in services from the scenario addressed by all of the stakeholders. **Scenario 2 is the one addressed by all of the stakeholder groups; it assumes a $30.6 million budget shortfall**. **Scenario 3 assumes a $20.6 million budget shortfall, t**herefore allowing for an additional $10 million allocation to services above Scenario 2.

Scenarios 1 and 3 were not addressed by the delegates in Phase 2; for those scenarios, therefore, DHS recommendations are shown only in comparison to the original proposed FY 2004-05 budget. In Scenario 2, the scenario addressed by all of the stakeholder groups, DHS recommendations are shown only in comparison to Version 1 of the recommendations from the delegates in Phase 2 in order to allow all of the comments from DHS to be displayed. Table 5 in the narrative shows the DMH recommendations compared to both Version 1 and Version 2 of the recommendations that emerged from Phase 2 of the process.

[7] It is never easy for people to participate in a process when they repeatedly find themselves diverging from the dominant views in the larger group. The DHS representatives frequently found themselves articulating positions that were not embraced by other delegates; still, the DHS representatives persisted, with great integrity and commitment, to share their perspectives and their understanding of the parts of the system they know best. As facilitator of the Phase 2 process, I believe the process was greatly enhanced by the participation of the DHS representatives, particularly in the ways they helped delegates develop a fuller understanding of the interdependent dimensions of the complex system of services and supports in LA County.

Attachment 6: Comments from DHS

1. **QUESTION: Recommendations** for where to make cuts **if budget shortfall exceeds $30.6 million.**
   SCENARIO 1: Projected shortfall: $40.6 million. Projected amount to allocate: $177 million

SERVICE CATEGORY	Proposed FY 2004-05 Budget	DHS Proposal	DHS Comments
General Mental Health Services			
Mental Health Services	12,775,000	9,500,000	Apply offsetting revenues of $1.7 M. Priority must be given to DHS referred patients, especially inpatients ready for discharge and recidivist patients
Crisis Intervention	3,094,000	2,000,000	Reducing services for PET. There has been an increase in funding the PET without corresponding increase to those services receiving these patients.
Residential Care/Interim assistance	4,000,000	3,000,000	Can we eliminate Interim Assistance if funding can come from Jails and be used by County department? Could be partially offset by SSI revenues.
Medication Support	5,651,000	3,000,000	This should be combined with MH services for economies of scale.
Day Treatment	1,028,000	0	
Self-Help/Consumer	1,500,000	500,000	Supportive of program, but DHS patients too critically ill to reap full benefits. Math to balance.
Case Management Brokerage/ Linkage	2,342,000	1,900,000	The Continuing Care programs at DHS hospitals should be continued, if not expanded. This program has been very successful at LAC+USC in placing patients to the right treatment setting when discharged.
Inpatient	7,400,000	5,000,000	DMH should negotiate rates/charity care provisions with private hospitals. Reimbursement rates to private hospitals have been more generous than those provided to DHS.
Mental Health Promotion	1,900,000	0	
Community Outreach Services	2,500,000	500,000	Math to balance.
Sub-total General Mental Health Services:	**42,190,000**	**25,400,000**	
Medication	39,234,000	28,000,000	DMH states they can negotiate reduced rates to equal no cuts from original $39 M projected budget
Juvenile Justice	2,031,000	2,000,000	Math to balance.
Forensic services	23,736,000	22,533,645	Math to balance. However, can jails subsidize these services through their budget?
Institutes for Mental Disorders	45,926,000	39,000,000	DHS does not support reductions to this area, unless DHS indigent patients can be guaranteed timely placement.
State Hospital	42,494,000	36,000,000	DHS does not support reductions to this area, unless DHS indigent patients can be guaranteed timely placement.
DHS	13,166,000	21,000,000	Additional funding needed to partially offset variable costs.
Public Guardian	2,047,000	1,975,000	Math to balance. We do not support any reductions in this service.
Administration	6,745,000	4,800,000	Math to balance.
Sub-total non-General Mental Health Services	**175,379,000**	**151,600,000**	
Unidentified curtailment	(44,592,000)	0	
TOTAL	**172,977,000**	**177,000,000**	

2. **SCENARIO 2 (The scenario addressed by all of the stakeholder groups): Projected shortfall: $30.6 million. Projected amount to allocate: $187 million**

SERVICE CATEGORY	Proposed FY 2004-05 Budget	Version 1: DHM +	Version 3: DHS	DHS Comments
General Mental Health Services				
Mental Health Services	12,775,000	11,100,000	9,000,000	Apply offsetting revenues of $1.7 M. Priority must be given to DHS referred patients, especially inpatients ready for discharge and recidivist patients
Crisis Intervention	3,094,000	2,300,000	2,500,000	Reducing services for PET. There has been an increase in funding the PET without corresponding increase to those services receiving these patients.
Residential Care/Interim assistance	4,000,000	3,500,000	3,000,000	Can we eliminate Interim Assistance if funding can come from Jails and be used by County department? Could be partially offset by SSI revenues.
Medication Support	5,651,000	4,800,000	3,300,000	This should be combined with MH services for economies of scale.
Day Treatment	1,028,000	0	0	
Self-Help/Consumer	1,500,000	2,500,000	500,000	Supportive of program, but DHS patients are too critically ill to reap full benefits. Math to balance.
Case Management Brokerage/ Linkage	2,342,000	2,300,000	1,900,000	The Continuing Care programs at DHS hospitals should be continued, if not expanded. This program has been very successful at LAC+USC in placing patients to the right treatment setting when discharged.
Inpatient	7,400,000	5,500,000	5,200,000	DMH should negotiate rates/charity care provisions with private hospitals. Reimbursement rates to private hospitals have been more generous than those provided to DHS.
Mental Health Promotion	1,900,000	0	0	
Community Outreach Services	2,500,000	2,000,000	500,000	Math to balance.
Sub-total General Mental Health Services:	**42,190,000**	**33,000,000**	**25,900,000**	
Medication	39,234,000	30,000,000	29,000,000	DMH states they can negotiate reduced rates to equal no cuts from original $39 M projected budget
Juvenile Justice	2,031,000	3,300,000	3,300,000	Mandatory amount per Susan Kerr
Jails	23,736,000	23,700,000	22,533,645	Math to balance.
Institutes for Mental Disorders	45,926,000	41,600,000	41,600,000	DHS does not support reductions to this area, unless DHS indigent patients can be guaranteed timely placement.
State Hospital	42,494,000	34,700,000	34,700,000	DHS does not support reductions to this area, unless DHS indigent patients can be guaranteed timely placement.
DHS	13,166,000	13,200,000	23,166,000	Additional funding needed to cover variable costs. If Mental Health initiative passes, DMH should reimburse DHS at SMA.
Public Guardian	2,047,000	2,100,000	1,975,355	Math to balance. We do not support any reduction in this service.
Administration	6,745,000	5,400,000	4,825,000	Math to balance.
Sub-total non-General Mental Health Services	**175,379,000**	**154,000,000**	**161,100,000**	
Unidentified curtailment	(44,592,000)	0	0	
TOTAL	172,977,000	**187,000,000**	**187,000,000**	

3. **QUESTION: Recommendations** for where to make cuts **if budget shortfall falls below $30.6 million.**
SCENARIO 3: Projected shortfall: $20.6 million. Projected amount to allocate: $197 million

SERVICE CATEGORY	Proposed FY 2004-05 Budget	DHS Proposal	DHS Comments
General Mental Health Services			
Mental Health Services	12,775,000	11,000,000	No net reduction. Apply offsetting revenues of $1.7 M.
Crisis Intervention	3,094,000	2,000,000	Reducing services for PET. There has been an increase in funding the PET without corresponding increase to those services receiving these patients.
Residential Care/Interim assistance	4,000,000	3,100,000	
Medication Support	5,651,000	4,000,000	This should be combined with MH services for economies of scale.
Day Treatment	1,028,000	0	
Self-Help/Consumer	1,500,000	1,250,000	Supportive of program, but DHS patients are too critically ill to reap full benefits. Math to balance.
Case Management Brokerage/ Linkage	2,342,000	2,320,000	The Continuing Care programs at DHS hospitals should be continued, if not expanded. This program has been very successful at LAC+USC in placing patients to the right treatment setting when discharged.
Inpatient	7,400,000	6,000,000	DMH should negotiate rates/charity care provisions with private hospitals. Reimbursement rates to private hospitals have been more generous than those provided to DHS.
Mental Health Promotion	1,900,000	0	
Community Outreach Services	2,500,000	500,000	Math to balance.
Sub-total General Mental Health Services:	**42,190,000**	**31,170,000**	
Medication	39,234,000	30,000,000	DMH states they can negotiate reduced rates to equal no cuts from original $39 M projected budget
Juvenile Justice	2,031,000	3,300,000	Mandatory amount per Susan Kerr.
Jails	23,736,000	23,736,000	
Institutes for Mental Disorders	45,926,000	41,600,000	DHS does not support reductions to this area, unless DHS indigent patients can be guaranteed timely placement.
State Hospital	42,494,000	36,731,000	DHS does not support reductions to this area, unless DHS indigent patients can be guaranteed timely placement.
DHS	13,166,000	23,166,000	Additional funding needed to partially offset variable costs.
Public Guardian	2,047,000	2,047,000	
Administration	6,745,000	5,250,000	Math to balance.
Sub-total non-General Mental Health Services	**175,379,000**	**165,830,000**	
Unidentified curtailment	(44,592,000)	0	
TOTAL	172,977,000	**197,000,000**	

4. **Comparison between the 3 scenarios**
   a. The difference between Scenario 1 (shortfall of $40.6 million) and Scenario 2 (shortfall of $30.6 million):
      - In Scenario 2, we restored funding for Medication Support, Inpatient, Medication, Jails, IMD, State Hospitals, and Administration that we had to cut in Scenario 2. DHS considers these services critical to DHS clients.
      - In Scenario 2, we increased DHS funds to estimated to cover its variable costs.

   b. The difference between Scenario 2 (shortfall of $30.6 million) and Scenario 3 (shortfall of $20.6 million)
      - Restored Mental Health Services at status quo.
      - Increased Medication Support to strengthen outpatient services.
      - Increased State Hospital funding to support discharge planning of patients who cannot be discharged to lower levels of care.

5. **Analysis of our overall approach to the funding recommendations**
   a. To envision and support the continuum of care as it currently exists without creating gridlock with patients awaiting treatment availability at lower/more appropriate level of care.
   b. As part of the funding recommendations, need to ensure the Mental Health safety net was at least minimally supported. The dollars allocated here do not fully support the program listed above.

6. **Analysis of particular funding recommendations**
   a. DHS budget allocation from DMH is inadequate and is below what Medi-Cal pays and what is currently paid to private contractors. Additional funding will preserve critical services to patients with chronic severe mental disorders:
      - Inpatient services provided at LAC+USC, H/UCLA, MLK/D, and Olive View Medical Centers:
        - 148 beds
        - 3000 admissions
        - 54,000 days
      - Emergency services provided at LAC+USC, H/UCLA, MLK/D, and Olive View Medical Centers:
        - 36,000 visits or over 360,000 units of service
        - the only psychiatric ER's in the County
        - fully staffed 24/7
      - Outpatient services provided at LAC+USC: 20,000 visits
      - Academic psychiatric programs containing 27% of all residency positions in California.
      - Safety net, accepting patients with Medi-Cal or no resources.
      - Serve patients that are homeless, comorbid substance use disorders, history of violence, and medical illness including HIV.
      - Work with law enforcement agencies. Majority of involuntary admissions to psych ER are from law enforcement.

b. DHS has already received funding cuts from DMH. In FY 2002-03, DMH reduced funds to DHS by $17.6 Million. DHS is also facing shortfalls in future years.

7. **Additional issues and reflections**
   a. We believe that DMH should consider all their product lines and not just the indigent care services before making decisions to cut (consider economies of scale and consolidation of services).
   b. DMH has indicated that most of the funds that may become available (SB 90) will not be used for indigent care. DHS believes an appropriate share of these dollars should be used for indigent care and support of the safety net.
   c. If cuts are made in IMD and/or State Hospital beds, admission from County hospitals need to be a priority, not frozen as proposed. This would create system wide gridlock critically overburdening both the Psych ER's and County inpatient services.
   d. If the Mental Health Initiative passes, DMH should consider reimbursing DHS at SMA rates.

ATTACHMENT 7:
LIST OF STAKEHOLDER GROUPS

What follows is a list of the groups that were invited to participate in both Phase 1 and Phase 2 of the Stakeholder process. Only the Courts chose not to participate in Phase 1 or Phase 2.

1. Client Coalition
2. Client stakeholder group, including client-run programs
3. Academic Partnerships
4. Association of Community Human Service Agencies (ACHSA)
5. Asian Pacific Policy and Planning Council (A3Pcon)
6. Black Community Health Task Force [did not participate in Phase 2]
7. CCC Steering Committee
8. Chief Administrative Office
9. The Courts, including Juvenile Court and Department 95 [did not participate in Phase 1 or Phase 2]
10. Department of Children and Family Services
11. Department of Health Services
12. Department of Mental Health, including line staff, Program Directors, District Chiefs, and the Leadership Team
13. Department of Public Social Services
14. Hospitals, including the Short-Doyle hospitals and the Hospital Association of Southern California
15. The Housing and Homeless Coalition
16. Latino Mental Health Council (LatCo)
17. Law enforcement, including the Sheriff's Department, Los Angeles Police Department, Long Beach Police Department, Pasadena Police Department, and the Los Angeles Police Chiefs' Association
18. Mental Health Commission
19. National Alliance for the Mentally Ill (NAMI)
20. Probation Department
21. Service Area Advisory Committee 1
22. Service Area Advisory Committee 2
23. Service Area Advisory Committee 3
24. Service Area Advisory Committee 4
25. Service Area Advisory Committee 5
26. Service Area Advisory Committee 6
27. Service Area Advisory Committee 7
28. Service Area Advisory Committee 8
29. United American Indian Involvement (UAII)

ATTACHMENT 8:
LIST OF DELEGATES AND ALTERNATES FOR PHASE 2

The number of delegates indicated after each group's name are the number of delegates assigned to the group for Phase 2 of the process.

1. Los Angeles County Client Coalition: 2 delegates
   - Delegate: Raul Villarreal 310-393-3340
   - Delegate: Ruth Hollman 310-305-8878 ruth@shareselfhelp.org
   - Alternate: Mercedes Moreno 818-347-7131
   - Alternate: Elaine De Roches 562-432-8502

2. Client stakeholder group, including client-run programs: 2 delegates
   - Delegate: Bill Compton 213-250-1500 bompton@mhala.org
   - Delegate: Ron Schraiber 213-637-2370 rschraiber@dmh.co.la.ca.us
   - Alternate: Gwen Lewis-Reid 213-637-2370 glewisreid@dmh.co.la.ca.us

3. Academic Partnerships: 1 delegate
   - Delegate: Karl Burgoyne, MD 310-222-3344 kburgoyne@rei.edu
   - Alternate: Milton Miller, MD 310-222-3101 iallen@dmh.co.la.ca.us

4. Association of Community Human Service Agencies (ACHSA): 2 delegates
   - Delegate: Kita S. Curry 310-390-6612 kcurry@didihirsch.org
   - Delegate: Bruce Saltzer 213-250-5030 blsachsa@pacbell.net
   - Alternate: Albert Urmer, Ph.D. 818-973-4899 ahu@ehrs.org

5. Asian Pacific Policy and Planning Council (A3Pcon): 1 delegate
   - Delegate: Gladys Lee 626-254-5000 glee@pacificclinics.org
   - Alternate: Herb Hatanaka 213-553-1800 hhata@sg.org

6. CCC Steering Committee: 2 delegates
   - Delegate: Yvette Townsend 213-738-3111 ytownsend@dmh.co.la.ca.us
   - Jim Preis 213-389-2077x13 jpreis@mhas-la.org
   - Alternate: Robin Kay 310-268-2507 rkay@dmh.co.la.ca.us

7. Chief Administrative Office: 1 delegate
   - Delegate: Rene' C. Phillips (213) 974-0564 rphillips@cao.co.la.ca.us

8. Department of Children and Family Services: 1 delegate
   - Delegate: Jackie Acosta, Ph.D. 626-938-1823 acostjc@dcfs.co.la.ca.us

9. Department of Health Services: 1 delegate
   - Delegate: Paula Packwood 213-240-8101 ppackwood@dhs.co.la.ca.us
   - Alternate: Patrick Ogawa 626-299-4695 pogawa@dhs.co.la.ca.us
   - Alternate: Helen Jew hjew@dhs.co.la.ca.us
   - Alternate: Laurie Aggas laggas@dhs.co.la.ca.us

10. Department of Mental Health, including line staff, Program Directors, District Chiefs, and the Leadership Team: 5 delegates plus either the Director or Chief Deputy
    - DMH District Chiefs
        - Delegate: Dennis Murata 213-738-4978 dmurate@dmh.co.la.ca.us
        - Alt: Debbie Innes-Gomberg 562-435-2337 dinnesgomberg@dmh.co.la.ca.us
    - DMH Leadership Team
        - Delegate: Cora Fullmore 213-738-4851 cfullmore@dmh.co.la.ca.us
        - Alternate: Ambrose Rodriguez 213-381-8363 arodriguez@dmh.co.la.ca.us
    - DMH Program Head
        - Delegate: Cathy Warner 323-241-6730 cwarner@dmh.co.la.ca.us
        - Alternate: Leticia Guzman 562-402-0688 lguzman@dmh.co.la.ca.us
    - DMH Staff Advisory Committee
        - Delegate: Bobbie Williams 323-939-6388 bjwilliams@dmh.co.la.ca.us
        - Delegate: Patricia Gilbert 310-798-5323 res09k2t@verizon.net
        - Alternate: Hector Garcia 626-390-7195 hgarcia@dmh.co.la.ca.us
    - Director: Marvin Southard 213-738-4601 MSouthard@dmh.co.la.ca.us
    - Chief Deputy Director: Susan Kerr 213-738-4108 Skerr@dmh.co.la.ca.us

11. Department of Public Social Services: 1 delegate
    - Delegate: Nadia Mirzayans 562-908-6863 nmirzaya@ladpss.org

12. Hospitals, including the Short-Doyle hospitals and the Hospital Association of Southern California: 2 delegates
    - Delegate: Heidi Lennartz 818-904-3596 hlennartz@mchonline.org
    - Delegate: Mara Pelsman 323-644-2000 mpelsman@gatewayshospital.org
    - Alternate: Lisa Montes
    - Alternate: Peggy Minnick

13. The Housing and Homeless Coalition: 1 delegate
    - Delegate: Mollie Lowery 213-488-0755 mollielowery@hotmail.com
    - Alternate: Ruth Schwartz 213-688-2188 ruthschwartz@shelterpartnership.org

14. Latino Mental Health Council (LatCo): 1 delegate
    - Delegate: Luis Garcia 626-254-5000 lgarcia@pacificclinics.org
    - Alternate: Ricardo Guajardo 909-623-6651 bridgeswrk@juno.com

15. Law enforcement, including the Sheriff's Department, Los Angeles Police Department, Long Beach Police Department, Pasadena Police Department, and the Los Angeles Police Chiefs' Association: 2 delegates
    - Delegate: Lt. Randy Haushaur 562-570-7292 randy_haushaur@longbeach.gov

16. Mental Health Commission: 1 delegate
    - Delegate: Jerry Lubin, 310-820-1181 jerry917@earthlink.net
    - Alternate: Barry F. Perrou 818-952-9800 drbfp@msn.com

17. National Alliance for the Mentally Ill (NAMI): 1 delegate
    - Delegate: Stella March 661-259-9439 smarch@nami.org

18. Probation Department: 1 delegate
    - Delegate: Gladys Nagy 310-668-3210 lgady_nagy@probation.co.la.ca.us
    - Alternate: Carol Salva 562-940-2532 carol_salva@probation.co.la.ca.us

19. Service Area Advisory Committee 1: 1 delegate
    - Delegate: Mary Ann Defever 661-575-1800 mdefever@dmh.co.la.ca.us
    - Alternate: Judy Cooperberg 661-726-2850 mhajudy@aol.com
    - Alternate: Stan Sorensen 661-726-2850

20. Service Area Advisory Committee 2: 1 delegate
    - Delegate: Ari Levy 661-259-9439 ari.levy@childfamilycenter.org
    - Alternate: Carl McCraven 818-896-1161 ccm@hillviewmhc.org
    - Alternate: Glen Cotham 818-896-1161 namisfv@worldnet.atl.net

21. Service Area Advisory Committee 3: 1 delegate
    - Delegate: Alfredo B. Larios 323-725-1337 alarios@ehrs.com
    - Alternate: Sue Shearer 626-254-5000 sshearer@pacificclinics.org

22. Service Area Advisory Committee 4: 1 delegate
    - Delegate: Ken Miya 805-379-8751 kkm2497@aol.com
    - Alternate: Stephen Rivera 323-253-4848 riverastp@aolcom
    - Alternate: Steve Kemp tuffey@usc.edu

23. Service Area Advisory Committee 5: 1 delegate
    - Delegate: Jacquelyn Wilcoxen 310-829-8711 jacquie.wilcoxen@stjohns.org
    - Alternate: Penny Mehra 310-785-2121 x 102 pmehra@alcottcenter.org

24. Service Area Advisory Committee 6: 1 delegate
    - Delegate: Mrs. Eddie Lamon rwoodruff@dmh.co.la.ca.us
    - Alternate: Anna L. Smith 323-298-3671 rwoodruff@dmh.co.la.ca.us

25. Service Area Advisory Committee 7: 1 delegate
    - Delegate: Shelley Levin 562-929-6688 shelleyl@telecarecorp.com
    - Alternate: John Robles 323-722-4529 jrobles@chcada.org

26. Service Area Advisory Committee 8: 1 delegate
    - Delegate: Martha Long 562-437-6717 marthalong@village-isa.org
    - Alternate: Lauraine Barber 562-429-6826 lgrams17@aol.com

27. United American Indian Involvement (UAII): 1 delegate
    - Delegate: Carrie Johnson 213-241-0979 drcjohnson@aol.com
    - Alternate: Anthony Stately 818-904-3596 astately@earthlink.net
    - Alternate: Rose Clark 213-202-3970 roselclark@aol.com