COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH
SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, September 21, 2016 from 9:30 AM to 12:30 PM
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90026

REASONS FOR MEETING

1. Provide an update from the perspective of the Director of the Department of Mental Health.
2. Initiate MHSA 3 Year Program and Expenditure Plan Process
3. PEI 3 Year Plan

MEETING NOTES

Department of Mental Health Update	**Dr. Robin Kay, Acting Director, County of Los Angeles, Department of Mental Health** • Board of Supervisors adopted our MHSA Annual Update. • October 1st Nami Walk **Continuum Care Reform(CCR)** • AB403 Continuum of Care Reform will change how services are delivered to children and youth that previously were in the Group Home System and in the Foster Family System. Target date to start is January 1st. Initially was led by DCFS and Probation with DMH joining in to provide enhanced services to children residing in shorter term out of home placements, including Short Term Residential Therapeutic Programs, up to 6 month of intensive treatment in an effort to ensure that children and youth are in family type settings. They will receive the treatment they need, move into the community more rapidly in an attempt to change the model of service delivery and care to children in DCFS system. DCFS is going to be looking for relative caregivers and resources for families that can provide more individualized care and treatment and support for the children that are in DCFS system with mental health issues. We are going to be looking for family-type placements for the children that we jointly serve. **Children System of Care** • At the prior meetings it was incorrectly stated that state hadn't appropriated funding for the mental health services associated with CCR. The legislature in the final budget for this fiscal year has appropriated funding but we are not convinced it's enough. We think Los Angeles County can use double of what was appropriated for the entire State. We are developing a realistic estimate now. There is a small group formed under leadership of Dr. Robert Byrd to review our cost analysis. We will be sharing it with representatives at state level. **No Place Like Home** • This is the State initiative bond measure, which will fund permanent supportive housing projects for people with serious mental illness. The expectation is that DMH will provide the supportive services, funded through MHSA,

Department of Mental Health Update (Cont.)	for the permanent supportive housing. In Los Angeles County the Board has also made a commitment to the City, which has its own measure on the November Ballot, which will help the City develop permanent supportive housing for people with mental health issues. The County and DMH will provide the support services for the people in those housing. No Place Like Home has moved forward and we are looking at a modified timeline for the role out. As we begin our planning for the Three Year MHSA Plan we need to be mindful of the fact that we will be increasingly called on to deliver the supportive services for people that are in both the State Bond measure supported housing and City housing. We could build 1,400 new units and the City could do something similar. • In the last year we have successfully moved the SLT approved and Board endorsed funds to CALHFA. Our Housing Advisory Board is going to be doing a request for additional proposals and we will be moving those forward. This puts us in good position when the Bond measures come through, because we will know what housing is in the pipeline. **<u>Jail Diversion</u>** • The County has formed the Office of Diversion and Reentry. Judge Peter Espinoza who has left the Bench and is heading that office, has been in place for couple of month now. They are looking at a more aggressive roll out of the projects that are in District Attorney Jackie Lacey's Jail Diversion Program. The parts that affect us most directly that we will see taking place in the upcoming year: o On the directly operated side we are going to be opening a Men's Reintegration Program similar to the Women's Reintegration Program. We are revamping that women's program in South Los Angeles. The men's program will open up on Skid Row as soon as the building is completed. o We are going to be issuing the solicitation for Forensic FSP slots that was approved last year by SLT. Also, we are going to be developing directly operated Forensic FSP slots, Justice-involved FSP slots. o There is recognition based on Misdemeanor Incompetent to Stand Trial Community Restoration Project, we need to develop more enhanced residential programs like the IMD step down programs. There is funding in the Reintegration or Diversion pool of funding for those enriched residential programs. We will soon start seeing expansion of enriched residential programs partly funded through that office and partly funded by us. o We continue to expand our collaboration with law enforcement. We have 24 new law enforcement entities within the last year that we partnered with. o Urgent Care Centers are an important piece of the Jail Diversion Program. The expectation is people who are picked by law enforcement for petty crimes associated with homelessness and/or mental illness, could if they volunteer to do so, be transported to Mental Health Urgent Care Center instead of being booked. o The legal issues are being worked out in a committee that is working with the District Attorney in anticipation of opening of the new Urgent Care Centers later this year. a. What those infractions are and what arrangements would be made? b. Would there need to be follow up? c. Would there be custody issues or this is a non-custodial program?

Department of Mental Health Update (Cont.)	Discussion, Q&A

	• Is No Place Like Home going to be funded through MHSA?
	  o Response from Dr. Kay – It's a State Bond Measure. The State organization will release the bonds. There is a local option for the administration of the bonds as well but we are still trying to explore what that local option would mean. Bonds will be released in four different funding rounds. The repayment of the bonds will occur; through the taking some of the MHSA funds off the top in Sacramento, before our MHSA funds flows down to Los Angeles County. The State initially assumed they would be able to issue the bonds this fall, based on recent information looks like the bonds won't be ready to be released for 18 months. When the bonds are fully sold, the money from it will amount to about $37 million. We will receive the remainder of the MHSA funding that will flow down to each of the Counties.
	• Los Angeles County has tried really hard to get housing for families with children. Lately I have been hearing a lot about families with babies 0 to 5 who are homeless. Is there something in the works down the line for them?
	  o Last year the County implemented the Family Solution Centers, which are located in all 8 Service Areas, where homeless families are engaged and receive a full range of services. They have been incredibly successful at engaging homeless families and getting them rapidly into housing.
	  o DPSS also has housing capacity for homeless families.
	  o Response from Maria Funk – Through the homeless initiative the Board of Supervisors approved the Homeless Initiative in February and there are 47 strategies that are being rolled out now. Some of them include more funding for families. The money is going to Family Solution Centers. In the past a lot of the funding going to Family Solution Centers was just for CalWORKs families and now with the expansion to the homeless initiative they will be able to server broader range of families.
	• Is there a list someplace that tells where in Service Areas the Family Solution Centers are located?
	  o It's on LAC's website and we will send it out.
	• Is there any consideration for homeless veterans, especially for those that don't qualify for VA under the 1,400 County and the City?
	  o Response from Maria Funk – The Veterans that receive services from VA have HUD-VASH vouchers for them (huge influx of them the Federal Government). Veterans that don't qualify are eligible for any other housing resource that we have. There hasn't been any planning to set aside money from housing for specific group. We still have Homeless Veteran vouchers to the city of Los Angeles for none connected veterans.
	• What is the City of Long Beach doing, because they have a big Veteran Population, around homelessness? Are they doing anything about housing?
	  o Response from Dr. Kay – We are not certain about Long Beach. This year we are going to see increasing differences on how all of the smaller City's address the issue of homelessness. There is a tremendous push on the part of the County and City of Los Angeles to get some of the smaller Cities to the table.
	• There is a huge African American population emerging. We need to make sure we are aware that this issue might come up in the near future.
	• One of the concerns for SAAC 4 is building trauma resistant families in our communities. Is there any update on that?

Department of Mental Health Update (Cont.)	o Response from Dr. Kay – The issue around trauma informed care and communities, families and children is everywhere. The INN 2 program will roll out this year and is focused on trauma for young children, school age children, TAY, adults, older adults and multi-generations of same family who have been exposed to trauma. We have discovered that First Five's major initiative for this year is related to trauma for young children and families. The Board has expressed interest in applying the literature on ACE (Adverse Childhood Experiences) and what we might do to identify them, and treat children and families who have been exposed to adverse childhood experiences. • We had round table with Native American consumers and family members. Their concern was that, the ones that were homeless that were arrested informed the officers that they had to have their medication were denied [SIC]. Is there a process that we can look into to help with this issue? o Response from Dr. Kay – The answer depends if people have been booked into City or County Jail. a. Up until September 1st DMH delivered the mental health services in County Jail (now transitioned to DHS). When concerned citizen learned that someone they knew was booked into County jail we have mechanism of alerting the staff in the jail. This is the number (213) 893-5543 that family members can call to notify the Sheriff Department stuff and DHS staff know that the person has been booked and they need this medicine. If you contact the Department we will also contact mental health staff in the County Jail. Within the jail we have teams that find people if they are not on special Mental Health Units to make sure a psychiatrist sees them and gets them their medication. b. County doesn't staff mental health services in city jail and people don't stay there too long. Cities are looking into developing consulting agreement with psychiatrists so they can do the same thing. • There is also another number you can call to find out who the clinician is if they are in the mental health part of the jail (213) 473-6183. Also, on Sheriff's website LASD.org you can see where there is a mental health link that has information and a form you can fill out with medication information and fax it in to them. Find out who the clinician is and leave a message as well get your loved one to give you permission to be able to speak to them. • San Fernando Valley Rescue Mission has room for families and their number is (818) 474-1295 and they are located in Northridge, Service Area 2. • Is there update on the Training Academy and can SLT have input in it? o Response from Dr. Kay – It's a concept right now. We have discussed about resourcing our DMH Training Division so we can expand the services we provide. We know that the providers are increasingly challenged with keeping staff that is trained in PEI practices. Talking about major County initiatives, it gives us the opportunity to develop a more deliberate training curriculum and career paths within the Department that will offer career enhancement opportunities for staff working in particular areas. • The understanding is MHSA funds the $2 billion that the State put aside is exclusively for buildings. The county doesn't get money for services and that money will come from MHSA. We end up spending more money for fewer services. Is there a thought about what happens when the cycle hits recession? o Response from Dr. Kay- The funding taken from the top will be to repay the Housing Bonds. That money leveraged with other City, State, other federal funding is to build the housing. When the buildings are constructed we need to identify MHSA money to support the services that people will receive in those housing units. We know that MHSA money is based on economy and there is concern about a worst case scenario: bonds are all sold, money came out from top of MHSA resulting is less of a county

Department of Mental Health Update (Cont.)	allocation, people move into housing and we have decrease in MHSA revenues and increase in the expectation of the use of MHSA to support people in housing. MHSA for short term is expected to go up but we know eventually it will come down. There are questions: will the funding come from all MHSA funding sources for the repayment of the bond? We suggested that in any given year that MHSA revenues fell below a certain level, the State would backfill the shortfall and they didn't agree to it. We are going to go back with CBHDA (County Behavioral Health Directors' Association) with ideas for guidelines and policy not contained in the legislation. There might be opportunities to allow people that are not in Full Service Partnership programs to become eligible for MHSA-funded rental subsidies (currently against MHSA CSS Housing regulations). We know that once people are stable in housing they don't necessarily need to be treated at a lower level of care than Full Service Partnership. o Response from Maria Funk – There will be work group formed related to No Place Like Home. The Board of Supervisors knows that there needs to be more money for services for people in housing. They have been exploring different ballot measures and they might have opportunity to put something on ballot in March. One of reasons No Place Like Home won't be rolling out for year and half is because there is a legal evaluation that has to occur. The HCD, which is the state agency that overseeing the No Place Like Home, plans to develop guidelines and policy before they do the legal challenge. • How much new money do we have? What are Board's priorities? How much money is placed for No Place Like Home? How much money is left over? o Response from Dr. Kay- Board priorities are homelessness, jail diversion, children and youth and foster care, health/mental health integration, children that are victims of commercial sexual exploitation.
MHSA 3 Year Program and Expenditure Plan Process	**Debbie Innes-Gomberg Ph.D., Program Manager III, MHSA Implementation and Outcomes Division, County of Los Angeles, Department of Mental Health** • Relationship between the SLT and SAACs: SAAC representatives are going to take back information from SLT to their SAACs and take the feedback from the SAACs back to SLT. Same thing will happened in the work groups. Examples might include: o If your SAAC identifies a population that's either not adequately served in our plan now or is not served that's the information we need for our 3 Year Plan. o Identification of service strategies that are either not being utilized or are under-utilized that are particularly effective. Maybe similar one to what Dr. Kay talked about earlier around trauma informed care, or it might be a service strategy around getting people into housing. MHSA 3 Year Plan Considerations: 1. Structure (work plan consolidation) 2. Target/Focal Populations - We need to look at the focal populations that are inadequately or underserved or not served. 3. Service Strategies- There might be more effective strategies. It could be evidence based practices, could be an emerging or promising practices.

MHSA 3 Year Program and Expenditure Plan Process (Cont.)	**Community Services and Supports (CSS) Plan** • CSS Work Plan Consolidation proposal-Aligning our system of care services with our current and future priorities We need to think of what our future priorities are going to be especially in the next 3 years. We want to make sure the system of care we adopt is consistent with our priorities: o Key focal populations o Effective service approaches o Ensuring services demonstrate outcomes • The last part of the meeting today will be to break out into age-focused work groups for CSS and PEI to initiate the work and agree on times to meet. The case for CSS Work Plan Consolidation: In 2006 our CSS Plan was approved by the State Department of Mental Health. Over the course of the last 10 years, we have added to the work plans that were originally in our CSS Plan. Each of those work plans was associated with a financial line item in the budget and a specific billing plan to use to claim for those services. This has resulted in administrative inefficiencies such as financial bucket silos and barriers to client flow. The proposal seeks to consolidate funding categories within CSS that result in more seamless care continuums and greater administrative efficiencies for providers as well as the Department. **CSS Work Plan Consolidation Table** • **Planning Outreach and Engagement (POE)** - Consists of planning and outreach engagement teams. These staff report to Service Area District Chiefs, outreaching to and educating the community on mental health service awareness, including specific ethnic populations. • **Full Service Partnership (FSP)** o Over the last 3 years we have identified specialized FSP focal populations such as justice-involved, chronically homeless and highly vulnerable individuals and those that meet the criteria for Assisting Outpatient Treatment (Laura's Law). o FCCS: We are proposing that some part of FCCS become an expanded FSP program (adopting State "at risk of" criteria) • **Alternative Crisis Services:** Consists of Residential & Bridging, Urgent Care Centers, IMD Step Down/Enriched Residential Services (Adult), Countywide Resource Management, Mental Health-Law Enforcement Partnerships (MHSA funded). • **Non-FSP:** Consists of FCCS (part of), Wellness/Client Run Centers (Adults),TAY Drop In Centers, Probation Camp Services (TAY), TAY Supported Employment, Family Wellness Resource Centers • **Linkage:** Consists of Jail Linkage & Transition and Service Area Navigation o Jail Linkage and Transition that are still funded by MHSA but those 11 or so are DHS employees but have same or more service expectations. • **Housing:** Consists of Housing for TAY and Adult, Housing specialists, MHSA Housing Program, Housing Trust Fund, Housing support team for No Place Like Home o Housing specialists are part of Service Area Teams that help people find housing. Example would be you

MHSA 3 Year Program and Expenditure Plan Process (Cont.)	might say there is specific strategy that might make those people's jobs more effective if they do this. **Discussion, Q&A** • Children and Family Crises service are in FSP column instead of the Alternative Crises Service column is the idea that you only get Crises Service if you're in a FSP like program or it's going to be available to any children /family that is having crises? We have TAY and adult service but no child service. o Response from Debbie Innes-Gomberg- It's the Respite Care for families of children that are in FSP programs. • What's Integrated Care Program? • Response from Debbie Innes-Gomberg - In INN 1 we funded the Integrated Services Management model (ISM) and the Integrated Clinic Model (ICM). At the conclusion of the Innovation program, for providers that were successful in that work, we couldn't continue to fund them with Innovation so we had to fund them with CSS and created a new CSS work plan called Integrated Care Program and SLT approved that recommendation. • Under Jail linkage 11 people are working there. That is not enough. When people are going to be released from jail they don't have enough time or people to get those linkage situations together people end up being let out that don't even know they are going to be let out. o Response from Dr. Kay- We have funded those 11 positions with MHSA funding there are additional resources that the Board contributes to Jail Mental Health Services as part of the consolidation, so that number might grow with additional available positions. • Is the fact Older Adults isn't in the bottom key a typo? o Response from Debbie Innes-Gomberg- What we did is we indicated where a service in the second row was a specific age group. There is no specific service for Older Adult only. • This is what exists now and when we get in our work groups we are going to make certain suggestions as in how we can change this or make sure the gaps are filled? For example in housing for TAY and Adults, we don't see children there so in the work group we can suggest children there? o Response from Debbie Innes-Gomberg- The slide we looked at was the structure. What we want you to look at is the target or focal populations (i.e.: housing services for children). Are there target or focal populations that aren't being addressed in those 6 proposed buckets? Do we have the service strategies to support the system of care that we are proposing? • Is this the only place in the planning process that Integrated Care would be addressed? It seems Integrated Care is a global model that goes across different populations. o Response from Dr. Kay- This is the primary place where and Integrated Care Program is reflected. There are some evidence based practices that were implemented as part of PEI services. Example of this is IMHT, where there is more time limited evidence based practices that focus on integration. You are raising both a structural question and a gap that we might want to look at. It shows up in both CSS and PEI. • Are you using and getting input from the people that are actually doing the program? They could help fill out the gaps better. o Response from Debbie Innes-Gomberg- Great suggestion for the Work Groups and the SAAC's. • What's happening with the integrated plan since this is the consolidation? Don't we have to integrate this with

MHSA 3 Year Program and Expenditure Plan Process (Cont.)

the rest of our mental health as well?
  - Response from Debbie Innes-Gomberg- When we did our last 3 Year Plan the State decided that the 3 Year Plan is a County's integrated plan. Next month we hope to invite Kim Nall to talk about the MHSA budget. If you have recommendations as part of this process for increased integration they should be incorporated.
- Are we going to make a recommendation in terms of whole budget or the MHSA budget?
  - Response from Dr. Kay- It's about rule of realignment and other funding as it relates to MHSA. Issue we are having is because realignment hasn't kept up with the cost of doing business and because realignment can be use in ways that MHSA cannot. Increasingly, we use realignment to pay for those things MHSA can't pay for. We are watching and participating in work groups at the State about realignment funding, both with regard to the formula and the amount of realignment that is waiting to be distributed by DHCS and the Department of Finance.
- My concern about that is because the money can be used for locked services and involuntary services we get to this, thought that it should all be used for those 2 things. We need to be aware for what else can be used with that money. We did have increase in IMD beds in last couple of years
  - Response from Dr. Kay- We have had so many limitations financially that we haven't had a chance to have that conversation but we are getting there. Remember that any increase in IMD beds has come from discretionary money that Board of Supervisors has set aside to pay for them and not through realignment or anything else.

Implications for CSS Work Plan Consolidation

- Administrative efficiency
  - For DMH: Fewer amendments
  - For Providers: Will allow for the provision of a range of services that meets a client/family's needs without transitioning clients between programs (This is about creating a Continuum of Care that has accountability yet has flexibility) or juggling funding
- Benefits for clients and families:
  - Supports a more seamless system of care

CSS Work Plan Consolidation Work Group Tasks

FSP:

- Agree upon a method for determining what portion of FCCS will migrate to FSP
  - Review FSP criteria from CSS Regulations
  - Operationally define "at risk of"
  - Ensure adequate service area capacity for FSP
  - Define service intensity and frequency for level 4 and 3 FSP

    Level 4 is the original FSP criteria which is LA county criteria. Level 3 is what CSS regulations allow which is at risk categories.

MHSA 3 Year Program and Expenditure Plan Process (Cont.)	o Identify outcome benchmarks by age group **Non-FSP:** • Map service continuum by age group • Identify any service continuum gaps • Develop service expectations • Identify outcome measures by age group o Symptom-based outcome measure (OQ, YOQ, IMR, health measures, etc.) o Functional outcomes relevant to service Functional outcomes are relevant to service. In full service partnership programs we look at reductions, hospitalizations, reductions in homelessness, grades improving. In PEI we measure decreases in depression, trauma, and disruptive behaviors. What we would like to do maybe in Non FSP category there are some relevant outcome measures that should be measured. Maybe in FSP there will be relevance in trauma measure. **MHSA Continuum of Care** • This is a balance. We want to think about the balance between the six (6) sorts of services: transition from institution, hospital and institutional diversion, intensive community services and supports, liaison functions to the community, PEI, Wellness and Self-help, and Peer. The decisions we make, we need to figure out where it falls in the balance.
PEI 3 Year Plan	**Lillian Bando JD., Program Manager III, Prevention & Early Intervention, County of Los Angeles, Department of Mental Health** **Time Line** • From September to November we have the work group meetings to come up with recommendations for any changes, additions, revisions for PEI 3YP which will be from the period of 2017-2020. We will get all the recommendations from the groups in November and we will consolidate them. In December we will have consolidated draft plan to present. In January we will go forward with the posting the plan. In February will be presented for public comments. In March the Mental Health Commission will review it and it will be presented to the Board by June. July 1, 2017 we will have 3 YP to go forward. We don't know how much money will be involved. We will have that figure in October when we have the budget meeting. **PEI Programs** • **Prevention Programs:** For all programs we have to identify risk factors and protective factors. This is through the PEI regulations. There is a great deal of focus on outcomes. • **Early Intervention:** We are going to look at if anyone is going to suggest any additional EBP; evidence based practices, community find evidence practices. We are going to want to have that vetted through our EBP selection committee • **Pilot Program**: We are going use small scale approach. We want to look at replicability. Are there other places in the County that need such program? Can we continue and sustain them?

PEI 3 Year Plan (Cont.)	The work groups are organized by age group and special populations. When you 1st did the PEI planning process it was from 2007 to 2009 and was a two year planning and was organized by Service Area groups and County wide group. Now it is a 2 month planning process and we are focusing by Age Groups (Children: 0-15, TAY 16-25 Adults 26-59, Older Adults 60+.) For the special population it includes: Veterans, Hearing and Vision Impaired, LGBT and others to be determined. We are doing it by age group to find out who is the focus of this. We will pass out PEI Workbooks. **Steps in Developing the 3-Year PEI Plan Workgroups** Step 1 : Review Existing Programs • We have currently 13 PEI programs. Programs are addressed as projects. What we would like to do in the future is to consolidate them to more accurately reflect how the services are being implemented. It's a reporting system it doesn't fully describe what the PEI plan is about. We looked at where we were and where we are. Right now PEI is mostly Early Intervention. We have 31 evidence based practices, 6 or 7 promising practices and number of Community Find evidence based practices. We have different focus of treatment with heavy emphasis on early intervention. We are looking at suicide prevention, school mental health, anti-stigma discrimination, anxiety, trauma, first break, emotional dysregulation difficulties, disruptive behavior disorders, parenting difficulties and sever behavioral conduct. Our EBPs on early intervention site are addressing these issues. When talking about PEI plans it's important to know where we fall in this continuum. We fall on prevention which is universal Prevention. We have selective prevention and we have early intervention. Our plan is heavily reliant on evidence based practices. If we do a trauma-focused cognitive behavioral treatment, we have direct mental health services that can be billed to Medi-Cal and we can increase the funding for our providers. Also, we have indirect mental health services some of them might be billed using our IBSS system. Enhance Services this maybe an opportunity if we are supporting our services. There are a lot of good services that maybe can be expanded or enhanced some way. For PEI plan look what else you can include into the EBP and surround it. Step 2: Identify Unmet Needs and Service Gaps • Identify Unmet Needs and Service Gaps o Review guidelines for PEI target and priority populations (all our programs have to serve under- served cultural populations, individuals experiencing onset of serious psychiatric illness; this was the exception to individuals with serious mental illness.) • List of Unmet Needs and Service Gaps o Identify unmet needs and service gaps (We look at age groups; we looked at race and ethnic groups. We looked at undeserved target population: homeless, foster youth, LGBT, Veterans. We looked at service gaps. We look at consultation, home visitation and expanded outreach) Step 3: Identify Risk Factors and Protective Factors • Identify Risk Factors & Protective Factors o Reducing risk factors or stressors: Risk factors are any circumstances that may increase the likelihood of an individual developing a mental illness o Building protective factors and skills and increasing support: Protective factors are any circumstances

PEI 3 Year Plan (Cont.)

that promote healthy behaviors and decrease the likelihood that an individual will develop a mental illness.

- Target Groups Identified
  - When we look at risk factors: We look at what's in the individual family, community and social. Some of these factors are hard to influence, like poverty and the neighborhood you live in, poor schooling, dysfunctional family. We need to look deeper then poverty. Let's be specific.

Step 4: Identify New PEI Programs

- Identify New PEI Programs
- Summary Program Descriptions
  - What is the specific need? What are the outcomes we want to have on this? What are the risk factors? What are the protective factors? What are the implementation issues and challenges? What are the outcome measures? You know the problems that exist so we want you to design it.

Step 5: Prioritize and Recommend Programs

- We have a lot of needs but not enough money. You need to prioritize it. Bring your experience and knowledge to the table
- Focus on:
  - Need -is it an unmet need?
  - PEI Target Population- is it appropriate? Is it at risk PEI populations?
  - Cost vs Impact
  - Implementation and Sustainability- is it easy to implement? If you know of ways we can make this program successful this is the time to bring it up.
  - Supporting Data Research-what it says? There has to be some data there. What information you track? Do your own evolution to support your program. At least track number of people served, type of services you provided, what you encountered, why people don't come to your services.

Discussion, Q&A

- Wondering will how this 3 YP will incorporate INN 2 since a lot of things we are going to look at where looked at in that process.
  - Response from Debbie Innes-Gomberg - If there are recommendations or thoughts on how we implement INN2 or how it applies to PEI go ahead and recommend those.
- On community based practices or promising practices is there anything done to incorporate spirituality in treatment.
  - Response from Lillian Bando - There wasn't as special practice dedicated to that. It would be more in terms of what agency did. We do have a number of trainings for clinicians for different way to help clients.
- Do we want to consolidate the 13 PEI programs?
  - Response from Lillian Bando - Yes we want to consolidate them because that's how we report to the state. It doesn't affect services. We might have evidence based practice that appears in 3-4 different

PEI 3 Year Plan (Cont.)	programs. • The data about outcomes from what we have done would that be available? The data that identifies need based on what we know now? Also projected area of needs? o Response from Debbie Innes-Gomberg - We can provide outcome data by practice and by service area. We are compiling the data for FY 15-16 now. If you need data it will be provided to you. • Do we have some data for PEI that has the white population broken down? o Response from Lillian Bando - We do have a break down by primary languages and it's in the work book. • EBP has had issue with trainings and their luck of cultural adaptations [SIC]. Can we do something about this? o Response from Lillian Bando - To change the content of EBT is with developer. The number of the developers indicated what has been adaptation within in their practice. We need to differentiate what is an adaptation and what is an accommodation (speaking the language in their place) within their practice. • We need something that is being used universal by all. o Response from Dr. Kay – Lilian has included information on how frequently the EBP have been used. Would encourage the work groups to look at it and look at the actual experience. • The Commission for Children and Family Services has been really concerned about kids that have been taken out of the home and about how they are traumatized. We recently learned most of the children in foster care have been taken out of their homes when they were under 5 years of age. Do we have any data what kinds of services are being provided to the children that are in the system with DCFS. The age group 0-3 needs to be focused. • Are we able to recommend changing some of the EBPs? Maybe recommending some community-based practices that are more appropriate to culturally diverse population? Can we make suggestions to our work groups? o Response from Lillian Bando - Yes that's what we are looking for. • How do we get other parents to be involved in those work groups? o Response from Lillian Bando - Back of the work group has the names and phone # of all facilitators so have them contract them. • We need to prioritize community children that are in the process of ending up in the system. o Response from Lillian Bando - That would be a prevention approach. In the PEI work group say what risk factors we are targeting to reduce the likely hood of individual actually coming into the system. What approach we can use. • My concern is that we have large number of work plans that we want consolidate. With integration and consolidation they are going to lose their viability and accountability.
Public Comment and Announcements	Public comment • Importance of Peer and Peer Support was mentioned.