COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH
SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, November 16, 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. Meet the Department of Mental Health's Director, Jonathan Sherin, M.D., Ph.D.
2. Receive summary of CSS and PEI work groups and provide feedback.

MEETING NOTES

Meet the Department of Mental Health's Director	**Jonathan Sherin, M.D., Ph.D., Director, County of Los Angeles, Department of Mental Health** Background: He grew up in the North East and did his post graduate training at UCLA. His training led him to a desire to serve underserved populations as a professional, over private practice. He got interested in the mission of taking care of the Veterans. In VA he went from being a researcher and clinician to taking care of veterans across the board. He became an administrative leader because he got frustrated with system issues. He started taking leadership roles in the VA. From the VA he went to Miami where he did same thing as the Chief of Mental Health for 4 Counties. He got recruited to work for an organization called Volunteers of America which he did for five years, a non-profit organization that has a mission of serving vulnerable populations in America. He got an opportunity to testify in front of congress a few times and this experience allowed him to broaden the spectrum of clients that he was trying to help. It brought his focus to integrated community health. About a year and half ago there was a settlement against VA for better use of the West LA VA brought Dr. Sherin to be subject matter expert and work on therapeutic plan for that campus, to design an environment that would support the wellbeing of Veterans who were suffering and their families. One of the things he learned there was the importance of input to drive a vast bureaucracy. As a member of that team he pushed the VA to get input from the stakeholders to drive the structure and the function of that campus going forward. **Discussion, Q&A** • When you got the lawsuit were you working with Bobby Shriver? How would that experience help in DMH in waking up sleeping people to step up sooner than later? o Yes I met Bobby because I was running metal health at the VA and he was a big advocate in getting housing on campus. The plan was to initially have 1,200 permanent supportive housing to upwards of 2,000 over time. In addition to having health care services in the housing, it had education, training, employment opportunities, benefits, and legal assistance. It also had entrepreneur opportunities, intentional interface with surrounding communities so that veterans reintegrate and flourish. It will have services and opportunities and will provide purpose of belonging. One of the things he recommended was to treat that campus as a club with membership. We should optimize mental health as opportunity and not treat mental health as a chore.

Meet the Department of Mental Health's Director (Cont.)	• Where is that campus? Was it given for housing for Veterans? o It was donated as home for veterans as part of Lincoln's vision as National Home. LA County has 10% of all VA's. While the number of homeless went up in LA County it went down in VA population because there was an intentional effort and resources put into the system to improve the way Veterans were engaged and had access to people that wanted to help them. • What are your thoughts on when a person is in full recovery for being able to lower their dosage of medicines? o One of his goals was always to decrease the regimen across the board. One of most impactful people in his training was a person from UCLA who founded the Eastern Medicine Department there. It's not about the dose or combination or changing the agent, we need to look at what's going on with the person. We need to look at the overall well-being of the person. • How much experience do you have working with First Nation populations? There are some of us that have not been reached. Are you willing to work with Native Americans/First Nation people to see how far we can go? o I have some experience with this population through his work with Volunteers of America. There were residential programs specifically designed to support First Nation's people. It took into account a lot of their cultural needs. In North CA I was developing a program with group called Yoha Day. We wanted to have mental health programs for all the reasons described. I am a huge a fan of peers. Shared experience, cultural competency is an amazing engagement tool and trust is critical in the first contact. Peer models that I have tried to get supported are ones, that there is that engagement and dealing with issues like stigma. Having a peer helps you get through the system and get to the information that helps with navigation process. • It's wonderful to hear your way of thinking and you seeing the person as a whole. We need to follow the recovery model and really take into consideration the client as a whole. In our Cultural Competency Committee we are here to work with you and advocate for a culturally diverse population. • Could you give your analogy as to what recovery means? o Recovery is a very important concept. Analogy would be: let's take a tree that isn't doing too well. It is planted in nurturing pod with the soil and minerals that it needs. Over time it will start doing well with continued resources and help. When you take that tree and plant it then it has the opportunity to reintegrate or integrate into larger entity and find way with help to become self-sufficient and independent. Our goal isn't just recovery its recovery and integration. We have this tendency to be scared and afraid of severe mental illness. We created locked environments that are controlled and those are not places people like to be. Having enriched environments that are not constrained are ways for people with needs to stay in safe area and grow on their own. • The most important thing for all of us is getting it early and dealing with prevention and early intervention level. You aware of the newly funded Centers of Excellence that focus on how we deal with 1st breaks and how we deal with community partnership. Collaboration with our flagship campus of the UC system here and campus in Sacramento will be a good way for us to stay connected. It is important for every County director to know that there is about $100 million a year in circulation for innovation. o Innovation is really important. Key is focusing on how do we connect with those that need help? What are the places that we need to focus our resources toward? We need to think strategically how to connect with

Meet the Department of Mental Health's Director (Cont.)	those individuals that need help and get them the resources. • As a former client I hope you are willing to listen to clients/consumers and get ideas from them as to what is needed as far as services and empower themselves. • Use your imagination and step out of behind the stigma curtain and imagine that you're in pure prevention, no limitations. What can we do to interrupt the pattern? How do we reach the broad spectrum of the population so we put ourselves out of business? o I was acutely aware of the need to engage veterans and developing their land and wake the VA up. I am idealist. The kids at school yard talk about going to a nurse because they aren't feeling good. We need to change our way of using language through educated dialogue and shared education. • The VA homelessness went down, the domestic violence homelessness went down, the substance abuse homelessness went down, the HIV homelessness went down but the mental health homelessness went up almost 11%. Part of it was because we take resources for whatever the flavor of the month is. We are your advisory committee and what commitment can we get from you to be here? o This is a monthly meeting and I will come in person every month. In this big bureaucracy we lose the sight of what is most important. What matters is the sacred interface between a provider and a client. We need to get the data from the trenches. What is happening in there is what should drive the direction of focus. o The Board of Supervisors is focused on Homelessness and Jail diversion and those are important things. With respect to homeless population we should take ownership of those that are homeless that are suffering with mental illness. **Public Comments** • You have uplifted and empowered me as a consumer because consumers haven't been empowered and haven't been given a chance to provide input. The people around the table don't represent me. When we talk about consumers we need to use peers for trainings and in general. We need current consumers to sit at table. • You do have parent peer and advocates that work with the department. You are invited to our meeting to talk about parent/peer engagement. • What you said gives me hope. We will stand with you to make the changes happen. There are few of us that get services that can contribute. What are the plans to meet with you to get your vision communicate with all levels of department including directly operated clinics, contract provider, SAAC's, Undeserved Cultural Community committees and consumers at large? It's not about what is said or written, it's about the connection. I Want you to be aware of the training called Emotional CPR. o I have heard about that Emotional CPR but don't know much about it and would appreciate if you could send me information about it. People have individual needs so certain things work for some people and not for others. Our goal is to put together services that will address the needs across the board. There are different coalitions and advocacy groups in Los Angeles. My hope would be that all the stake holders will help develop the structure. The trenches needing to be empowered on both sides. The data needs to drive the decision making.

Overview of CSS Work Plan Consolidation	**A. Housing** • This has been under discussion with collaborating partners Department of Health Services, Public Health, CEO and some of the board offices. There are number of initiatives that would require the overall department to enhance the services we deliver to homeless individuals, particularly those that are in permanent supportive housing programs. The Board has made a commitment that all individuals that are placed in Permanent Supportive Housing Units through the Measure HHH approved by the voters will be provided with whatever supportive services needed. It is estimated that the County would create 10,000 units (1/3 of those units will be reserved for people with mental health issues). We can expect that our services will need to be enhanced so we can fulfill that commitment. • The County homeless initiative is led by Phil Ansel. He has been looking at strategies to develop homeless service standards, expectations that can be conveyed to providers that deliver those supportive services to ensure we do the best job possible. • On site services are considered to be best practice. There needs to be presence in Permanent Housing programs so that when clients need assistance there is no delay. **Faming for the New Model** • Board mandate to ensure all people in Permanent Supportive Housing (PSH) receive appropriate supportive services. • Homeless Initiative strategy to develop supportive services standards. On-site services are considered a best practice. • Health Agency homeless workgroup developing an integrated model based on best practices. • No Place Like Home o $2 billion statewide bond. o Los Angeles is estimated to receive $800 million. o Depending on the leveraging, 1,500 to 5,700 units will be developed for DMH clients. • HHH -- Memorandum of Understanding between County and City of Los Angeles for County to provide services in the housing that is developed o It is projected to build as many as 10,000 units and we would be obligated to provide the mental health services for individuals in those units. • Based on the Following Principles: o Maximizing leveraging of each Department's resources and of Medi-Cal. o Increasing efficiencies. o Maximizing the expertise of each Department. o Creates flow in FSPs as clients transition to on-site services **Permanent Supportive Housing (PSH)** • SAMHSA Evidence-Based Practice • We know it works

Overview of CSS Work Plan Consolidation (Cont.)	o Reduces risk of death o Improves lives o Can result in increased engagement in Mental Health Treatment o Can result in decreased drug/alcohol use o Saves public money • Targets people that are homeless and have a disability • Tenant holds a lease and there is no time limit on length of stay (permanent) • Tenants have access to the support services o Supportive services are key to successfully maintaining housing o Offering services is mandatory but accepting services is voluntary **Current DMH Model for Supportive Services in Permanent Supportive Housing (PSH)** • MHSA Housing Program -- DMH invested $126 million in the development of PSH • 46 projects countywide and 990 MHSA units • 1,900 tenant based subsidies • DMH does not have dedicated funding to provide services to tenants of PSH • Services are connected to client not the housing resource • Service commitment made by the program where the client receives at the time they are housed **Current DMH Model Challenges** • Services are not consistently on-site • Many different mental health agencies providing services to the tenants in one building – causes confusion for property manager • Some programs do not provide adequate field based services • Some programs are unwilling to assist the client with the housing process including the housing search • Some programs are concerned that they cannot bill for housing services • Clients get disconnected from services and cases are closed so no one is seeing the client • When there is a housing related problem (e.g. hoarding, isolation, disrupting other tenants, non-payment of rent) there is no service provider to intervene • Developers have concerns about partnering with DMH under this model **What we have learned from Department of Health Services** • Intensive Case Management Services (ICMS) o Master Agreement o Housing related supportive services o Site based and mobile teams o Every client that is matched to housing resources is also assigned to an ICMS provider • Developers prefer this model

Overview of CSS Work Plan Consolidation (Cont.)	**ICMS Service Package** • Conduct housing needs assessment • Assist client with obtaining necessary documentation • Assist with completing and submitting housing application • Assist with housing search including negotiating rental agreements • Provide eviction prevention support and intervention • Conduct home visits and submit quarterly reports as required • Assist client with accessing and keeping appointments for health, mental health and Substance Use Disorder(SUD) services • Assist with life skills • Assist with educational and volunteer opportunities • Transportation • Assist with obtaining benefits **Over-Arching Goals of Redesigned Services** • Provide comprehensive services to tenants of PSH to achieve long-term stability and improved health and well-being. • Implement a standardized and easily replicable mechanism to ensure that supportive housing tenants have access to ICMS, specialty mental health and substance use services. • Utilize each Department's ability to leverage Medi-Cal revenue to offset the cost of services including through Whole Person Care, Drug Medi-Cal waiver and mental health Medi-Cal. **County's Proposed New Model of Supportive Services** • Designed to ensure all of those that move into Permanent Supportive Housing receive supportive services • One uniform County model • Inter-Agency Intensive team o Intensive Case Management Services o Specialty Mental Health Services o Substance Use Disorders • Provides a FSP level of services o Field-based, intensive, low case manager/client ratio, 24/7 response capacity, whatever it takes. **Funding for New Model** • Leverage the ICMS funding which is $450/client/month = $5,400/year/client • Proposed mental health funding $8,000/year/client including leveraged Medi-Cal. • Estimated 1,000 units per year o MHSA funding $8 million o Leveraged ICMS funding $5,400,000 o Leveraged DMC funding unknown

Overview of CSS Work Plan Consolidation (Cont.)	Discussion, Q&A

- In developing this model did you consider the relationship of the tenants if they decline services? If clients come in and are questioning the services being offered or are not willing to participate in the services are their housing offered independent of that?
  - There is separation. Services are voluntary and residency isn't dependent on that. This allows us to serve more people. The department has received a lot of feedback because of our current model only people that are current clients can get into the housing. This will allow other people with mental illnesses that haven't connected to come into the housing and have the services offered to them.
- Is SLT being asked to approve this or is this a done deal?
  - This is part of the Three Year Planning Process. This is a County driven initiative. We are presenting it today and approvals will be happening next month
- Is there collaboration from the Health Department? Will Health Department fund part of it?
  - The DHS is providing the ICMS services. Part of the ICMS job is to make sure that everyone has a Health Home and they are able to access it. The Health Department will fund the ICMS and the health services through the Health Home.
- The housing for families and the children that are names as client. How does this mix in with matching funds? In some cases you can't use matching funds if the parent is not the one identified with mental health services. Also, how would matching funds work if some don't have Medi-Cal?
  - This model can be provided even if they are not using Medi-Cal. Some of the ICMS will be matched through Whole Person Care. Our intention is to serve all tenants weather they have Medi-Cal or not.
- Is there any kind of safeguards in place to avoid the drift that has happened in previous programs from the low case manage to client ration to not so low ratio?
  - Our goal is to have low case management to client ratio and the combination of ICMS stuff. Our intention is to keep that ratio low so we can provide the services needed.
- Would it require DSM diagnosis to be eligible for the housing?
  - For our housing that targets people that have mental health issues they do have to meet certain requirements including having serious mental illness or in case of child serious emotional disorders.
- Offering the services is mandatory and accepting services are voluntary. Will there be a lens on that specific part of the process so we can see if there is a connection or disconnection there? Those not accepting services might cause issues in bigger picture.
  - If you have stuff that is on site they see people and can engage to people. There will be much bigger lens with stuff on site.
- What about your undocumented immigrants and people coming out of the prison. How would you work with that population with them being homeless or not?
  - The housing we built includes housing for those people. There is a huge effort to focus housing on reentry population and DHS is the lead on that. DMH is partnering and creating more housing opportunities. We want to keep creating housing opportunities for all the people we serve.
- What is the plan for coordination since some of it is DHS money and some of it is DMH money. How will the two services providers be coordinated? Will there be some requirements?

Overview of CSS Work Plan Consolidation (Cont.)	o There will be since they are going to be an integrated team. One discussion is that many of the ICMS providers are also DMH providers so will be ideal if an agency can provide those services if they are both. Not everyone that is an ICMS provider which is great too because we can expand our network for people who have expertise in homeless services. We will work together as an integrated team kind of like our Integrated Mobile Health Teams. • The ICMS model does it have Peers on the team? o Many of them do have Peers on the team even through its not required. **MHSA 3 Year Plan Status Updates** Each age group will now present the status of their 3 year plan efforts for CSS Work Plan consolidation and PEI. They will take your feedback and finalize for our December 21st SLT meeting. The groups tried to define what "at risk means". FCCS will no longer exist and it will belong in the non-FSP bucket and we will have FSP programs that serve an expanded population. It will be extended to include people that are at risk of being homeless, going into institutions, etc. The work groups are operationalizing what at risk means, what methodology and will be used to determine the level of care within FSP which means identifying a level of care system. They are going to talk about service area needs. What are the markers of success? What outcomes should we track that aren't being tracked. In the non-FSP program work plan what does the continuum look like? They will identify gaps in services and what types of services this group should receive? **B. Older Adult** **Full Service Partnership Services** **1. How do we operationalize what "at risk" means? What are the characteristics of "at risk"?** • Factors that would put an older adult at risk include: lack of supportive family connections, lack of economic resources and ageism in the job market, physical decline, cognitive decline, lack of social support due to isolation, fear of losing independence, inability to drive, sensory deficits brought on by normal aging, substance use and abuse, lack of older adult focused mental health services in the community, stigma related to older adult mental health services, increased stigmatization in some cultures or in individuals who are recent immigrants, fear some type of reprisals such as deportation if services are accepted, elder abuse, long term incarceration and history of involvement in the criminal justice system. • Institutionalization: An older adult may be “at risk” of institutionalization if their current community setting or placement does not adequately meet their physical, social, psychological, health or other needs. In addition, the lack of a support system and access to supportive services (IHSS, peer support etc.) also places an older adult at risk for institutionalization. Multiple chronic health conditions along with a mental health condition may also place an older adult at risk for institutionalization. • Out of Home Placement: “At Risk” in this category often involves family members and others not being able or willing to provide care and/or support due to the nature or severity of physical, psychological and/or substance use conditions. No or limited social and/or family support. Fall risk, due to chronic health conditions and numerous medications (unsteady gait, decreased vision and difficulty ambulating on uneven surfaces).

Overview of CSS Work Plan Consolidation (Cont.)	• Hospitalization: Factors that may contribute to an older adult being "at risk" in this category, include untreated or inappropriately treated mental health, health and/or substance use conditions, in addition, suicide ideation or attempts. Failure to coordinate and take both health and psychotropic medications as prescribed. No or limited social, family and/or community support. Limited or no connection to non-emergency community services. Food and income insecurity. None or inadequate housing. • Incarceration: An older adult may be "at risk" of incarceration if they do not have a meaningful way in which to spend their time (volunteer, work, recreation etc.). Further, no or limited income, no or inadequate housing and inadequate access to mental health, health and substance use services may be factors that contribute to an older adults' risk of incarceration. Prior legal/incarceration history may also be aligned to "risk of" incarceration. Little or no family or social support. Absence of peer and other social supports. **2. What methodology, if any, will be used to determine the levels of care within FSP?** • There are several options available for determining level of care for older adults including the Older Adult MORS, and the Determinants of Care. Those on levels 1-4 on the OA MORS scale may be considered for FSP, in addition to the FSP criteria. A rating of Levels 5-7 in addition to the FCCS criteria may constitute FCCS level of care. **3. What will be used to determine the level of need for each Service Area? How do we ensure the need is met?** • The level of mental health services needed for each service area will be determined based upon data (service utilization/expenditures) and input from Older Adult providers in all service areas. To ensure that the identified service needs are addressed and met, available resources need to be aligned with the service areas that need more service capacity. The recommendation for the MHSA CSS Three-Year Plan is that both OA FCCS & FSP services be increased by at least 15% countywide to begin to widen system capacity and improve access to care. **4. What are the markers for success for this age group? What outcomes should we track**? • Meaningful use of time and capabilities, therefore reducing isolation • Safe and affordable housing • Healthy and supportive relationships • Reduction in incarceration in jails • Reduction in institutionalization and reduction in out-of-home placements • Timely access to needed help • Client satisfaction **Non-Full Service Partnership Programs** **1. What services are currently available for this age group?** • Individual, Group and Family Therapy

Overview of CSS Work Plan Consolidation (Cont.)	• Tele-psychiatry Services • Flex Funds (excluding rental subsidies) • Care Management • Medication • Jail In-reach • Outreach & Engagement • Referral & Linkage • Assessment • Substance Use Screening • Cognitive Screenings • Limited Wellness Activities • Health Screening **2. Are there currently any gaps in services for this age group?** • Limited FSP slots • Large number of OA's served in programs without older adult specific services • Limited continuum of care – No wellness component within most programs • Severe capacity shortage in some service areas • Limited housing resources/supports • No Older Adult navigators • Need for more flex funds for housing and to purchase ancillary items such as hygiene products, adult diapers, transportation assistance • Need to expand peer support **3. What types of services should this age group expect to receive?** • The older adult population with mental illness should expect to receive a broad comprehensive range of services that can adapt and change, as the need of the older adult changes. The service continuum should range from intensive services (FSP) to minimum support (wellness/peer support.) • Service Expectations: o Field Based o Medication o Mental Health o Case Management o Peer Support/Counseling o Money Management o Community Partnership/ Volunteering o Crisis Support o Wellness Recovery Action Plan

Overview of CSS Work Plan Consolidation (Cont.)	o Substance Use Screening o Wellness Services **4. What outcome measures will adequately assess the success of a client? Symptom-based outcome measure? Functional outcomes relevant to the program?** • The following outcome measures are available to assess the success of a client: o Patient Health Questionnaire (PHQ-9) o Geriatric Depression Scale (GDS) o Outcome Questionnaire (OQ) o Milestones of Recovery Scale (MORS) o Determinants of Care • The functional outcomes relevant to the program which may indicate success include the following: o Reduction in hospitalization o Reduction in days homeless o Reduction in incarcerations o Improvement in quality of life o Improve social connectedness o Increased meaningful use of time (volunteering, college, etc.) o Outcomes Measures Application (OMA) data elements **C. Adult** **Full Service Partnership Services** **1. How do we operationalize what "at risk" means? What are the characteristics of "at risk"?** • Homelessness: An adult who is unable to live to the requirements of their lease, as evidenced by the following and not limited to: Loss of funding which will impact sustained housing, hoarding, that will lead towards eviction, 10 day notice to vacate, symptoms of illness which impact their ability to keep stable housing, history of destruction of property, unable to care of upkeep of apartment, ongoing conflict with neighbors and/or landlord, couch surfing /living in car less than 120 days, inability to pay bills, budget, shop and cook without support. • Criminal Justice System: Factors that may contribute to an adult at risk of involvement with the criminal justice system include but are not limited to the following: Engagement in unlawful and risky behavior, Unable to pay fees (i.e. parking tickets, jay walking tickets, court fees, etc.), unknown warrants, two or more contacts with law enforcement in the past 90 days, and the Inability to follow requirements of probation. • Psychiatric Hospitalization: Factors that may contribute to an adult at risk of psychiatric hospitalization include but are not limited to the following: At least one encounter with an emergency outreach team, in the past 90 days and does not meet criteria for 5150, two or more visits to a Psychiatric Emergency Room in the past 90 days, two or more visits to an Psychiatric Urgent Care Center in the past 90 days, and two or

Overview of CSS Work Plan Consolidation (Cont.)	more visits to a Medical Emergency Room for a psychiatric disorder in the last 90 days. **2. What methodology, if any, will be used to determine the levels of care within FSP?** • Milestones of Recovery Scale (MORS) • Determinants • State Required Outcome Measure Application (Adult 3 –Month) & (Adult Key Event Changes) • Improved/Increased involvement in the community • Decreased incarcerations or client involvement with law enforcement • Adult FSP Discharge Readiness Toolkit o Need for less case management services o Lowered need for crisis intervention o Utilization at psychiatric services o Utilization of support systems – family, community engagement, resources o Stable housing o Less interaction with the justice system o Less psychiatric hospitalizations o Decrease in symptoms/increase in functionality **3. What will be used to determine the level of need for each Service Area? How do we ensure the need is met?** • Official homeless count • Demographic analysis • Current slot allocation for each service area and identify service areas which are currently underserved or do not have the capacity to provide FSP services to its community. • Re-Entry Population Referrals, prediction of where clients will be referred • Whole Person Care Referrals, consideration of where clients will be referred **4. What are the markers for success for this age group? What outcomes should we track**? • Increased participation in volunteering and peer related activities • Graduation from FSP services to lower level of care within at least 5 years • Maintain stable housing • Assure Linkage/Connection to medical care/receiving medical treatment • Marked increase in obtaining and /or maintaining sobriety • Reducing the length of stay in for clients who have been at that level of care for 3 or more years • Increased number of clients attending school and/or vocational programs • Reduce the number of “lost” FSP clients • Independent medication compliance and/or engagement with Psychiatrist • A reduction in psychiatric hospitalizations, both admissions and days • Increase in positive Key Event Changes (KEC), and KEC reporting

Overview of CSS Work Plan Consolidation (Cont.)	• Increase number of clients engaged in meaningful roles in the community • Increase number of clients engaged in employment related activities • Reduction in homelessness • Reduced client need for field based services • Increasing the number of client who have established benefits; Relying less on CSS funds • Reunification with family/peers • Maintaining positive support system • Reduced number of After-hour phone calls • Decrease in Symptoms/increase in functionality • Increase the number of clients meeting/exceeding care plan goals **Non-Full Service Partnership Programs** **1. What services are currently available for this age group?** • Peer Support • Wellness Services • Self-Help Support Groups • Mental Health Groups • Individual Mental Health Services including Evidence-Based Practices • Medication Support • Supportive Employment • Case Management • Supportive Housing Needs • Linkage to resources • Co-Occurring/Substance Use Disorders Support and Services • Benefits Establishment • Outreach and Engagement • Some field based services • Education Support Services • Culturally Sensitive Satisfaction Survey. • Integrated services • Smoking Cessation Services • Healthy Living Skills • Spirituality Supportive Services (Spirituality Tool Kit) • Life Skills Training • Referral, linkage and collaboration with Healthcare Providers, Integrated Care • Community Integration • Wellness Recovery Action Planning (WRAP)

Overview of CSS Work Plan Consolidation (Cont.)	• Jail-in reach
	• Peer Run Respite
	• Enriched Residential Services
	• Senate Bill 82 outreach
	• Tele Psychiatry
	• Alternative Healing Methods
	
	2. Are there currently any gaps in services for this age group?
	• Addiction Residential & outpatient services for individuals with drug use issues, gambling issues, including detoxification services
	• Culture Specific Peer mentoring services (specific cultures in need of support)
	• Sufficient Employment supportive services
	  o Business establishment entrepreneurial training
	  o Individual Placement and Support (IPS) Supported Employment
	• Transportation
	• Trauma-informed care
	  o Generational trauma
	  o Trauma delivery service
	• Auxiliary services
	• Housing
	  o Supported housing
	  o Transitional housing
	  o Housing services – county based transitional support
	  o Affordable Permanent housing
	  o Shelter Beds
	  o Collaborative Housing
	• Supportive employment (IPS)
	• Health care navigation team/linkage to healthcare
	  o Physical
	  o Dental
	  o Eye
	• Client Supportive Services Funding
	  o Housing/outcome evaluation
	• Family treatment Services
	• Impact meetings with Navigation teams with FCCS
	• Educating hospitals, jails of criteria of FCCS LOC
	• Community Outreach Services
	• Housing for undocumented clients
	• Medication Supportive Services

Overview of CSS Work Plan Consolidation (Cont.)	• Sufficient LPS certified staff • Labor Trafficking • Wellness/SA 1 • Culturally Based Wellness Services/Mobile Wellness Services for Underserved Communities • PRRCH in all Service Areas • Sufficient Warm line support • Money Management/Payee Services • Self-Help Support Groups • Develop relationships – culturally appropriate outreach/engagement • Increase navigators in every Service Area **3. What types of services should this age group expect to receive?** • Employments Career Development • Medication Supportive Services • Mental Health individual and group treatment • Supportive Housing • Case Management & Linkage • Linkage to Immigration supportive services as needed • Community Integration, facilitate joining providers and clients/their families to community resources (i.e. police, hospital, community leaders, etc.) • Increased Wellness Holistic Approaches • Impact meetings for FCCS (it's happening at some agencies but not others) • Transportation Assistance • Tokens and TAP cards/linkage to access/bus pass • Legal support and expungement • Timely access to services Cultural appropriate services at all levels **4. What outcome measures will adequately assess the success of a client? Symptom-based outcome measure? Functional outcomes relevant to the program?** • Health needs assessment • Network of belonging/social connectedness • Assessment of Social Supports • Meaningful role assessment • MORS Scale • Self-coordinate own life – more self-independence • Required State Outcomes • Patient Health Questionnaire (PHQ-9) • Connection to primary care

Overview of CSS Work Plan Consolidation (Cont.)	• Quality of life • Quality improvement • Client Satisfaction • Historical tracking of LOC, to ensure clients are being transitioned when clinically appropriate • Culturally sensitive surveys • Annual check-in / iHomes • Social connection with customer satisfaction **5. To identify the intensity and frequency differentiation between the levels of care within FSP:** • Forensic/Intensive FSP: 24/7 availability, client has recent incarceration and/or involvement with the justice system, multi-disciplinary team, client contact at least twice a week, 65% field-based services, jail in-reach as required, housing support and assistance, Substance Use Disorder services, benefits establishment as needed, at least monthly Psychiatry support, unlimited peer support, 1:10 staff to client ratio and integrated care across the Departments within the Health Agency. • FSP (level 4): 24/7 availability, multi-disciplinary team, at least weekly contact, 65% field-based services, jail in-reach as required, housing support and assistance, Substance Use Disorder services, benefits establishment as needed, monthly Psychiatry support, unlimited peer support, 1:15 staff to client ratio and integrated care across the Departments within the Health Agency. • FSP (level 3): 24/7 availability, multi-disciplinary team, at least bi-monthly contact, at minimum 35% field-based services, housing support and services, Substance Use Disorder services, benefits establishment as needed, bi-monthly Psychiatry support, unlimited peer support, 1:45 staff to client ratio and integrated care across the Departments within the Health Agency. **D. Transition Age Youth** **Full Service Partnership Services** **1. How do we operationalize what "at risk" means? What are the characteristics of "at risk"?** • First psychotic break • Currently homeless or at imminent risk of being homeless • Unstable, sporadic housing/multiple placements • Exiting and/or aging out of the criminal justice and/or child welfare system • Currently involved Commercial Sexual Exploitation of Children Youth (CSECY) or youth with a history of CSEC involvement • Co-occurring substance abuse and mental health issues **2. What methodology, if any, will be used to determine the levels of care within FSP?** • Milestones of Recovery Scale (MORS) • Specific determinant of youth level of care including o Unable to manage his/her own financial resources and require formal or informal money

Overview of CSS Work Plan Consolidation (Cont.)	management. o Unable to coordinate his/her own transportation needs to and from appointments, education, occupation activities, and/or other meaningful life activities. o Requires formal or informal assistance with 2 or more ADLs. o Requires at least once per week support and/or care coordination. o Requires formal or informal assistance or support to manage his/her medication. o Requires formal or informal assistance or support to manage community relations and minimize disruptive behaviors. o Stable at the current MORS score for less than six months. o Receiving flex funds to meet basic needs (housing and food) **3. What will be used to determine the level of need for each Service Area? How do we ensure the need is met?** • Review needs and current capacity for each service area for the last 3 year fiscal years • Identify service gaps and adjust capacity accordingly • Ensure that each SA is maximizing their current capacity by reviewing expenditures for TAY providers for the last 3 fiscal years **4. What are the markers for success for this age group? What outcomes should we track**? • Securing and maintain stable housing (ability to maintain housing for at least one year) • Creating and sustaining healthy relationships with at least one adult/family figure • Creating and sustaining healthy relationships with at least one peer • Securing and maintaining employment (ability to maintain steady employment for at least one year) • Graduation from high school or completion of GED • Enrollment in community college or a vocational program **Non-Full Service Partnership Programs** **1. What services are currently available for this age group?** • TAY Housing • TAY Housing Specialists • MHSA Housing Program • TAY Drop In Center Services • TAY Navigation • Wellness Services • Peer Led Support Groups • TAY Enhanced Emergency Shelters • Justice System Diversion Services • Probation Camp Services

Overview of CSS Work Plan Consolidation (Cont.)	• Women's Reintegration Jail Transition Services • TAY Supported Employment **2. Are there currently any gaps in services for this age group?** • Special populations such as LGBTQI2S, CSECY, boys and young men of color, domestic violence, human trafficking **3. What types of services should this age group expect to receive?** • TAY Housing Specialists: Provide case management, advocacy, and housing retention, facilitate communication between parties, and assist with completion of rental application, linkage to financial benefits. • MHSA Housing Program: Provide subsidies for Unit-based Permanent Supportive Housing programs and "Youth-Oriented" board and care-type (non-licensed) to address long-term housing needs eligible for Full Service Partnerships (FSP) and others coming directly from transitional housing programs or directly from foster care or group homes. • TAY Drop In Center Services: provides basic supports (food, shelter, hygiene, social and emotional support) and linkages to health, mental health, substance abuse, employment and housing services) for TAY who are homeless or at risk of homelessness. • TAY Navigation: Provide assessments, outreach and engagement, individual short term treatment interventions, linkage/referrals to appropriate mental health services, and consultation to County Departments and community providers. • Wellness Services: Provide individual, group, family therapy, medication management, rehabilitation, case management, and peer support in an outpatient setting. • TAY Enhanced Emergency Shelters: Serves immediate and urgent housing needs for temporary shelter for up to 36 nights. Also includes mental health assessment, individual short term therapy, group therapy, case management, and linkages to needed resources. • Justice System Diversion Services: Provides mental health assessments, individual, group, family therapy, medication management, rehabilitation, and case management. • Peer Led Support Groups: Provides psychoeducational groups, anti-stigma and discrimination, advocacy, social skills building, social connection, and linkages to community resources. • Probation Camp Services: Provides mental health assessments, individual, group, family therapy, medication management, rehabilitation, case management and linkages to community resources. • TAY Supported Employment: Provides evidence-based employment services in the community. **4. What outcome measures will adequately assess the success of a client? Symptom-based outcome measure? Functional outcomes relevant to the program?** • Both Symptom-based outcome measures as well as functional outcomes relevant to programming (i.e.: Securing employment/education, social connection, particularly for disenfranchised TAY are key functional outcomes)

Overview of CSS Work Plan Consolidation (Cont.)	**E. Child** **Full Service Partnership Services** **1. How do we operationalize what "at risk" means? What are the characteristics of "at risk"?** • Children and adolescents identified as Seriously Emotionally Disturbed (SED) are eligible for FSP (Intensive) services. Eligible SED Children as a result of the mental disorder has substantial impairment in at least two of the following areas: o Zero to five year-old (0-5) who: ➢ is at risk of expulsion from pre-school (e.g. past suspensions) ➢ parent/Caregiver involved in Domestic Violence ➢ has a parent/caregiver who has SED or a severe and persistent mental illness, or have a substance abuse disorder or co-occurring disorder o Child/Youth who is unable to function in the home and/or community setting: ➢ has psychotic features ➢ has suicidal and/or homicidal ideation ➢ has violent behaviors ➢ has recent psychiatric hospitalization (s) within the last six months ➢ has Co-Occurring Disorder (e.g. substance abuse, developmental or medical disorder) ➢ is transitioning back into less structured home/community setting (e.g. from Juvenile Hall and/or Group Home placement) ➢ has a parent/caregiver who has SED or a severe and persistent mental illness, or have a substance abuse disorder or co-occurring disorder ➢ is at risk of or currently being homeless (e.g. eviction, couch surfing, domestic violence, parent unemployment) o Child/Youth who is experiencing the following at school: ➢ truancy or Sporadic attendance (e.g. tickets, SARB) ➢ suspension or Expulsion ➢ failing classes o Child/Youth who: ➢ is at risk of or has already been removed from the home by DCFS (e.g. Seven day notices or multiple placement history) ➢ is at risk of or is currently involved with the Juvenile Justice system (e.g. contact with law enforcement and/or Juvenile Hall entries) ➢ is at risk of or currently a victim of Commercially Sexually Exploited Children (e.g. youth having multiple sexual partners) ➢ has a Parent/Caregiver involved in Domestic Violence

Overview of CSS Work Plan Consolidation (Cont.)	**2. What methodology, if any, will be used to determine the levels of care within FSP?** • While CSS workgroup members recognize the need to identify specialize programs such as Katie A., they strongly believe that the needs of children and families change rapidly and children's services should be as broad and flexible as possible. Based on this belief, workgroup members recommended avoiding the creation of levels of care within FSP and instead focus on meeting the unique needs of individual children and families. • 3-5 times for high level and lower level will be twice a week **3. What will be used to determine the level of need for each Service Area? How do we ensure the need is met?** • There was a thorough exploration of the needs of each Service Area over the course of the CSS Workgroup meetings. It was evident each Service Area shared the desire for increased FSP (intensive) services and increased flexibility to better serve their unique communities. CSS workgroup participants indicated that all Service Areas had the following similar needs: o Housing o Bilingual staff o Translation services (specifically for indigenous languages) o Increased intensive mental health services capacity o Increased residential placement and psychiatric beds **4. What are the markers for success for this age group? What outcomes should we track**? • Outcomes will be tracked through the Outcomes Measure Application (OMA). • Placement stability: o Number of days in an out of home placement o Number of days in an acute psychiatric hospital o Number of days in Juvenile Hall • Education o School Attendance o School Grades o Age appropriate involvement in school activities • Social Support o Socializes with others o Receives spiritual support, if appropriate o Experiences age appropriate positive peer and family relationships **Non-Full Service Partnership Programs** • **What services are currently available for this age group?** • Moderately intensive services are currently available based on client need. An array of mental health services is available to children and families receiving Field Capable Clinical Services. The services

Overview of CSS Work Plan Consolidation (Cont.)	include: o Individual and Family Therapy o 24/7 Telephone Crisis Response o Specialized COD Assessment and treatment interventions for the child o Case Management/Linkage o Medication support as needed o Family Education & Support • **Are there currently any gaps in services for this age group?** • The CSS Workgroup identified several gaps throughout LA County for this age group. These gaps include, but are not limited to: o Non-intensive outpatient services o Housing support o Access to residential placement o Lack of psychiatric beds o Immigration services o Indigent funding o Community resources (housing, medical, transportation, etc.) o Consistent use of a Parent Partner o Lack of bilingual staff o Services for Unaccompanied Minors o Substance abuse services o FCCS flex fund restrictions o • **What types of services should this age group expect to receive?** • The Non–Intensive service array should include the following: o Community Outreach Services (COS) o Individual and Family Therapy o 24/7 Telephone Crisis Response o Specialized COD Assessment and treatment interventions for the child o Case management / linkage o Medication support as needed o Family education and support o Flex Funds o Respite Care services • **What outcome measures will adequately assess the success of a client? Symptom-based outcome measure? Functional outcomes relevant to the program?** • The CSS workgroup recommends using a modified version of the current FCCS OMA to adequately assess client success.

Overview of CSS Work Plan Consolidation (Cont.)	• The possibility of utilizing the YOQ was discussed in the CSS workgroup; however, CSOC Administration must first research other symptom-based outcome measures that will assist in gaging client progress. CSOC Administration will also explore outside outcome measures which may be imposed by outside agencies (i.e. EPSDT) • The following functional outcomes will be used to assess the success of the program: o Education/Vocational ➢ School attendance ➢ Improved grades ➢ Appropriate involvement in school activities o Social Interactions ➢ Age appropriate positive relationships with peers and family members ➢ Appropriate involvement in the community o Placement Stability o Justice System Involvement • Levels of care once a month to twice a week **F. Access Pathway** • **Issues Raised:** 1. Need to re-engage those who pre-maturely drop out of services 2. Calls received by NAMI of family members in crisis 3. Families often not engaged in services for adult clients 4. Transitions not managed well a. Hospital to mental health care b. Consider role of Community Health Workers with Whole Person Care pilots • **Went over "Existing pathways Handout"** o There are number of teams and individuals that play a role in access: ➢ SB 82 mobile team is on the left, Service Area Navigators and Outreach and Engagement stuff. Those stuff report to service area district chiefs. ➢ On the right side we have Peer Run Respite Houses (2 of them), Peer Bridging Services and NAMI. ➢ In the middle you have verity of different programs : Crises Intervention program, the Faith Imitative that are conduit between faith community, the Health Neighborhood work that is going on in the service area, the Jail Linkage stuff, Integrated Care Programs, Parent Advocates, Urgent Care Centers. • **Potential solutions:** 1. Enhancing coordination among key access pathway resources a. Involve Service Area District Chiefs

Overview of CSS Work Plan Consolidation (Cont.)	b. Enhance and/or formalize the role of peers and family members/NAMI i. Review and consider Mentors on Discharge model 2. Identify and implement successful access strategies a. Review SB 82 Mobile Triage Team approach and outcomes 3. Consider role of SRTS database 4. Build upon and utilize Under Served Cultural Communities Capacity Building projects material and work to promote culturally relevant outreach and engagement that builds trust and results in successful linkage to early intervention services. • Helena and Jim : o We also talked about concept of peers as hand holders for moving though the system. Every time consumers go to new program they have to give up their relationships and start new relationships and the continuity is broken. We discussed the gap of access between the systems. Warm hand of is not enough. We need to think of a way of continuity in terms of responsibility for clients who can be identified as needing ongoing resource to stay in the system. **Discussion, Q&A** • They had several meetings for us to put our inputs. For those that had have complaints you could have participated. • Make sure in the groups you looked at the Undocumented Population especially with the scare of the deportation. In the TAY group I am glad they are looking at boys of color. Make sure we look at from none traditional aspect as well • This format is perfect since its same for all age groups. • Glad to see the Faith Initiative on there because it's important. • For access pathways I see the role of Primary Care and Community Health Centers as how we can work to transition care and how the role can be coordinated into access to mental health services were its not stigmatized. The role of schools in access to care we need to created better linkages there because they are none stigma orientated. We have shortage of counselors in schools and we don't have stable funding source for it. There can be linkage in school setting to diversion programs so people don't get into Criminal Justice System because once they get in its a slippery slope to incarceration and their records get ruined. o We talked about feeder organizations but there is direct service work that is accessing. • Pleased to see that in the Adult services area sobriety is one of the markers for success. • With the increased need for supportive services with increased housing and increase with whole Person Care initiative and Jail Diversion focus there is going to be more and more need how are we building in utilization review process so that we can create flow because we can't afford to continue to increase slots. o The discussion that has been going on in the department and Stake Holders is the utilization of levels

Overview of CSS Work Plan Consolidation (Cont.)	of care system that would inform transitions and inform interventions. The issue of benchmarking outcomes is what we need to start looking at. • You are missing the Mental Health Promotores as one of the cultural ways of getting people in the system. • I don't see the Health Neighborhood Initiative should be there as separated category. Want to point out the idea of linking and making sure that we are working with the support systems in the community such as the schools and faith organizations, as well as other community support services that people can use not only as access but to also support. Working with families and other ages groups is important. • On the diagram you have Peer Run Respite but not the Peer Run Centers. That is a huge portion of assessing and pathways. For TAY CSS will you be providing data for level of needs for each service area? For the Children can you give examples of what services will be provided 3-5 times a week for intensive cases? For Older Adults please look into why service area 1 has 25 FSP because we have bigger need. • For TAY under number 3 what will be used to determine the level of need it would be nice to identify some markers for underserved populations that use demographics and analyze why those populations are undeserved. Under number 3 what types of services: with peer support groups we need to emphasize the need of culturally sensitive and diverse peer leaders from different ethnicity? As a program things that would provide support to reconnect with their parents and family members is important. For Children under "at risk" add cyber bullying. What would be used to determine the level of need? One of the things we finding out that for FSP there aren't enough agencies to provide those resources and that should be considered as one determinant. Under Systems of Care we need to look at what are they System of Care for 0-5 that are already in place and how we can better utilize that. Under none FSP 2 gaps show the lack of bilingual stuff as a need and we need to add lack of 0-5 trained stuff. • Is MORS a national evidence based practice? How does it overlap with levels of care? o MORS is level of care scale that several counties are using developed by MHALA. • For Adult System of Care CSS report there wasn't consent around the ratios reported here. There was comment that 1 to 45 ratio was too high so this isn't an ideal report. • For cultural base wellness adult touched on this but other groups didn't touch this. What would this look like? • For markers for success for TAY we don't look at where the students are struggling at and can be looked as at risk factor. Enrollment in college should focus on freshmen year and drop outs. Don't forget families with TAY. For Older Adults focus on isolation (cultural/language/educational). • For TAY, Adult and Older Adult substance dependence have training for co-occurring to clinicians can understand that it's much more complicated as to having one or the other. Consider the idea of harm reduction as opposed to total abstinence which sometimes isn't that realistic. We need to pay attention to Harm Reduction in LA County. • This seems vague and it's not clear how exactly the system will look differently particularly in terms of budget and how much money we have. At risk depends on the criteria and its vague what determines it.

Overview of CSS Work Plan Consolidation (Cont.)	o There will be budget group that focuses on PEI and in particular to spending. There will be another budget group to focus on CSS and funding FSP slots. • On the Older Adult one of the big needs they identified was lack of support system and peer support. Older Adults has been resistant to self-help support groups. They are available by telephones and Skype. On children they are saying that they need at least one peer but in reality they need way more than one peer. Last Three Year Plan we allocated money to start self-help support groups for children that never came out and instead we spend the money on art supplies. In TAY we don't have self-help support concept. We have peer lead support group that isn't same thing as self-help support group. • Adult CSS group indicated culturally appropriate services the other age groups need to include this as well. **Public Comments** • The Children and TAY aren't addressing the Access issue. The Access issue exists due to private insurance. There is accessibility issue when someone has private insurance. Look into providers to do paper work to get FSP and so they don't get denied because they have private insurance. We are very limited to accessing Parent Partners and Parent Advocates. • You to focus under 1 % in Healthy Hope Families that need help in everything. Child 0-5 needs help in the area of individual care take or providers. • How is at risk developed and defined? Has end users of each group been asked to define at risk and how they see this language? How are the stakeholder inputs across the Los Angeles County collected and what the process looks like?
Overview of PEI Work Plan Changes	In the last Three Year Plan we didn't address PEI. It's divided into four age groups and County Wide. They will address priority populations, unmet needs and service gaps. They are focusing on Prevention, Early intervention and stigma reduction. In December meeting there will be presentation for the drafts plan that will incorporate the recommendations not only presented today but will include more information. Cultural relevancy is throughout all of this. The budget information will be talked in the budget work group. **A. Child** 1. School-aged children at high risk for developing depression and anxiety – education and prevention activities o This area we were looking at providing opportunities for education and prevention activities. We are focusing on the isolated and quit child. 2. School-aged children -- culturally competent school-based prevention services to address stigma reduction, anti-bullying and mental health awareness. o We are making sure at school level we are addressing the mental health needs and raising awareness and having opportunity to reduce stigma and bullying. 3. Young children in preschools and childcare at risk for expulsion for disruptive behaviors – education and prevention activities. o They will address the children that have the disruptive behaviors and we can mitigate those issues before the age of three.

Overview of PEI Work Plan Changes (Cont.)	4. Perinatal and post-partum women in need of mental health supportive services (Non-CalWORKs)-- services to reduce the risk of maltreatment and neglect for children ages 0-5 o Specially looked at 0-2 and 0-3 group. This particular area addresses the need of those young children as well as new parents. 5. Preschool-aged children – develop prevention strategies and tools to enhance their socio-emotional development. o Making sure we address the social and we are addressing the social and emotional needs of the children. **B. Transition Age Youth** 1. Commercial Sexually Exploited Children and Youth (CSECY) -- outreach, education and prevention activities. o They are stigmatized and they are in DCFS or Juvenile Justice. 2. First Break TAY -- outreach, education and prevention activities o Sometimes they can mask/hide their issue through behavioral issues. How can we reach to them earlier? 3. LGBTQ TAY at risk of trauma -- outreach, education and prevention activities. o We need to outreach to them earlier so they don't feel there is a stigma associated to them. 4. Underserved ethnic groups (African/A-A, API, and Middle Eastern) and immigrant TAY families -- outreach, education and prevention activities o Many Ethnic groups weren't being serviced. These are families that might have acculturation, inter-generational issues, and fear of deportation that isn't letting them get what's out there. 5. High school aged TAY-- education on mental health trauma informed services and substance use /co-occurring disorders 6. TAY at risk of juvenile justice involvement services -- outreach, education and prevention activities o How can we reach youth at earlier stage? We can provide mental health trauma based services and substance abuse informed service. **C. Adult** Main topics were cultural sensitivity and appropriate services. Making sure its integrated across care as well as peer support throughout our services. 1. Families of individuals with serious mental illness -- family support services. 2. Pregnant/postpartum depressed women -- home visitation, treatment and parenting services. 3. LGBTQ People of Color -- outreach, education and therapy. 4. Socially isolated adults -- prevention programs to reduce social and emotional isolation. 5. Recently homeless individuals and families – develop and implement PEI related strategies. 6. Adults at risk for suicide -- suicide prevention expansion for language capability. 7. Victims of domestic abuse -- education and trauma informed services. 8. Race/ethnic minorities – training on working with different populations and sustaining treatment.

Overview of PEI Work Plan Changes (Cont.)	**D. Older Adult** 1. Abused and neglected older adults with mental illness – outreach, education, and prevention activities o As they get older and more frail and vulnerable and social support system declines we have to watch for abuse. Providing education around this group is very important. 2. Older adults with depression who have not been identified for mental health services due to stigma and/or fear of discrimination – strategies to improve identification o Older adult access care a lot of time through their primary care. We are not seeing those people make it to our system. Having intervention will help us access Older Adult population that are dealing with depression. 3. Older adults with co-morbidities – services to reduce emotional and physical pain. o The older you get you have more aches and pains. The chronic health conditions have impact so we want to tailor with appropriate practice with this population that is experiencing both emotion and physical pain. 4. Older adults with mental illness – services to reduce social isolation. o We want to prevent social isolation because if you're socially isolated you are not connecting and you have no one to communicate with and you have no one to support you. 5. Caregivers of older adults with mental illness – services to reduce social isolation o We know that when individual is a caregiver their own needs are put on the shelf for a while. They don't get regular Medi-Cal care. We want to support care givers to keep the structure in place. 6. Older adults impacted by generational, historical or current trauma – programs utilizing reminiscence activities o The older you get there are many different types of trauma. Things you could do before you can't now that's a change. We want to top into a practice that will address trauma around older adults whether it's historical or current trauma. **E. Countywide** 1. Children at risk for bullying – education and anti-bullying activities. o Children that are perhaps dealing with mental health issues to being with. We are looking at prevention as well as risk facts (any circumstance that increases the likelihood of an individual developing a mental illness). 2. Mental health consumers -- family and peer support services. o Looks at psycho education and family support services for families and care givers of individuals with mental illness. 3. LGBTQ People of Color (POC) services –outreach, education and therapy. 4. Immigrants and refugees at risk of developing a mental illness -- outreach, education and prevention activities. o LA County is designated as refuge impacted county. They need services. We are looking at prevention services to go into community and access the services needed. 5. Veterans – peer outreach, education and prevention activities o LA County has high population of Veterans and the needs are vast. 20 troops take their life on daily

Overview of PEI Work Plan Changes (Cont.)	bases. We need more services. Prevention should be synonymous with outreach and engagement. **Discussion, Q&A** • For TAY work groups the Los Angeles Unified School District has been doing a lot of work. In terms of the Universal Targeted Intensive Interventions we do intervention known as Focus. We provide 10 week classroom intervention within whole grade level in issues such as emotional regulation, goal setting. We do More Then Sad intervention which focuses on depression and suicide prevention. Also, we do mental health awareness campaigns and activities. We provide trainings to our stuff regarding trauma and having more trauma sensitive lens in terms of interactions with students. For targeted level, for student that return a conscious screen we screen a number of our students and we found out a number of our students have had complex trauma so we do trauma screening (that not only looks at trauma but looks at physical health, oral health, depression, anxiety and substance use). We do this for pregnant students too and provide them with TSEBT's. Also, we provide intervention call CIBITS which is a trauma group that helps young people process trauma. On intensive level we provide services in terms of school based psychiatric social workers. We provide individual and family therapy using EBPs. • What PEI can do is housing specially for those that are newly diagnosed. Add homelessness to TAY, County Wide and Older Adults. • There are 81 school districts in LA County. We need to ensure they have access to services. For Adults Victims of abuse should include sex trafficking and labor trafficking. • We need to think about how we are going to outreach and engage to Adults. • As a Native American of First Nation can we have a work group to educate DMH? • Great work on all of the work groups. Was good to hear the need for culturally sensitive services. It's important the money for training for cultural competent providers is there. It's important for us to include the trash-hold languages when we do the outreach. We need to go to the people and not expect them to come to us. • The Board has priorities do they realize that if people are in the system it's not a preventive method? When we talk about outreach the biggest problem was that we didn't have enough services for the families. • Parents are not families they are more than family so there has to be a distinction. We need to look at Veteran's families. o There are different ways you can do outreach. You can have involvement of peers to do outreach. You can have individuals with livid experiences in that community or cultural group. A lot of it whether it's through ECPR, Mental Health First Aid, QPR or use of Promotores its focused on community education and outreach. We are trying to move away from four walls and provide the services in the community. • You mentioned that you are working with DCFS so I am assuming your somehow connecting mental health services to the kids in the system. One of the areas the commission is concerned with is the 0-3 population. About the 3rd of a report of kids taking away is in that age group. That trauma needs to be recognized or accepted as a special population. Would like to see some kind of connection with DCFS that trains the parents or the resource families. • When you go out to Outreach and engage the communities you need to send people out that are not afraid of the community that they are going to. You have to go there let the people know you are part of them and you can't be

Overview of PEI Work Plan Changes (Cont.)	afraid. • The faith communities are involved in different aspects of DMH. In the Three Year Plan what roles can they have in each of the age groups? The Faith Leaders are the first respondents and can be identified as #6 on county wide population. The clergy are asking to be trained in disaster response. • We need to really think about the issues of 81 school districts in Los Angeles County. Lack of counselors is creating major problems. We need to put self-help groups in every one of these age groups for prevention and early interventions. • When we talk about trauma make sure we are looking at the fear of the deportation. We need to train Law Enforcement, Probation Officers and training teachers and counselors. • If we expand outreach to not just be finding people to link services but finding people to educate, finding people that we can do prevention work with, providing them information and tips, refer then to support groups. Outreach and Engagement should be look at as more than getting them in a clinic. **Public Comments** • We need to involve the Faith Community in every aspect we do. We can't do effective services unless we include people that feel like their spirituality is important in their life and that they use. • It is really important to have it designated as number 6 in the County Wide Special Population for faith communities. • The DMH doesn't write latter for children court or any other court. • Foster Care has their tools 0 to 24. We call it AB 12. They no longer have to be on the street and be homeless. Each care taker is trained. The schools already know about the Foster Care Kinship system. • There is new rapid housing money for those that are not chronically homeless and we can take advantage of those subsidies. • We need to be able to access the school districts. The districts are not allowing teens/students unless there are MOU's contented to the schools and it creates more obstacles. • One under TAY it makes sense to have additional column for youth exiting Foster Care. The Youth that go into foster care 0-3 who are in out of home care need special attention (should be 0-5). • What is stigma and stigma reduction plan in school because the title alone is stigmatizing. ECPR gets mentioned but it's not happening we want it to happen. For Older Adults in Home Supportive System how will that work? When mentioning depression mention it in sadness because a lot of times people don't know they are depressed but they know they are sad. o We are doing ECPR and it's not on the self. We need to have way to inform people of things that are going on. We are trying to get things done. • What is an iHome? o IHOMS is a web-based application developed by UC San Diego for use in the collection and reporting of outcomes. The Department used the system as the data portal for our evaluation of MHSA Innovation 1. • How does LACDMH define advocacy? o From Debbie Innes-Gomberg- I am not sure if the Department has an official definition, but in general

Overview of PEI Work Plan Changes (Cont.)	advocacy refers to public support or recommendations related to a specific policy or cause. • What is trauma-informed care? What does this concept look like in practice? How does one (client/provider) know if this type of care is being implemented? o SAMHSA (Substance Abuse and Mental Health Services Administration) refers to systems that are trauma-informed as: (1) realizing the widespread impact of trauma; (2) recognizing the signs and symptoms of trauma in clients families, staff and others involved in the system; (3) responding by fully integrating knowledge about trauma into policies, procedures and practices, and (4) seeking to actively resist re-traumatization. • Need additional information on self-help support group vs peer support group. • Need additional information on evidence based practices.