COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH
SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, June 21, 2017 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 on behalf of the County of Los Angeles Department of Mental Health
2. Provide an Update on Legislative issues of importance to Mental Health
3. MHSA 3-year Plan Implementation
4. Emerging Innovation Projects

MEETING NOTES

Department of Mental Health Update	***Jonathan Sherin, M.D., Ph.D., Director, County of Los Angeles, Department of Mental Health*** Jonathan Sherin talked about the reorganization of the Department. There is a lot going on in Sacramento that is important and impactful. Regarding the reversion of money, we stand to keep and maintain to leverage a lot of resources if we get certain legislation passed or signed off on. **We need to:** • Proactively design our programs, • Deliver our services across the continuum of care, • Evaluating our performance in doing that, • Need to have the right policies in place to do our work, • Need to have a support system that is accessible to all those different areas, The goal is a wonderfully designed set of programs, delivered seamlessly, performing well, all supported. We need to make sure the Department is being positioned properly going forward. We want to optimize our effectiveness in accessing more and more resources because we would be recognized for doing such a fantastic job. Age is critical. We need to look at across counties what we do in age group, because there are different challenges and needs along the continuum. There are other things like gender, different situations, and different diagnoses in addition to age to consider. We need to proactively look across the board of the different populations and how they may have special needs. We need to look out at our levels of care to make sure they are attending to the needs of the different populations, not just based on age. We need to be intentional with our outreach and engagement strategy in each of the areas of service delivery. We need to look at the needs of individual groups and create programs to address them. As we move across the

continuum of intensity in the outpatient sector you move toward stabilization and treatment, etc. Reintegration for children is different than reintegration in someone who has been homeless.
On the outpatient side it is about service and stabilization and the backside is about opportunity and empowerment. We need to have prevention strategies in place - but not organized or set up or supported to intentionally push their mission according to the function.

We want levels of care available to every population in need. We have the opportunity to design the different levels of care to those needs. I call that the factory - that's what we do, and we do that through a tremendous number of incredible community providers. We need to make sure the factory is doing all those different things for all the populations that have need. We need to be intentional about doing that.

In order to know how the factory is doing, we need to assess the performance of the factory and that comes in many shapes and sizes. We have Compliance, QI, QA, but we need to be very strategic in terms of our resources and how they are currently being distributed and consolidated. We need to find out if the resources that we have are effective. It is important to know if we are performing and are using our resources effectively.

The policy piece is a big one, we need to be optimized and find the constraints. When you are working in the trenches you are trying to help someone, but instead you spend all your time with bureaucratic stuff, which makes it difficult. That sacred trench needs to be empowered and enriched, not used for other purposes.

Overall direction of the Department:
We need to have strategic communications externally and internally.
We need to have strategic development - we do a pretty good job at drawing down money. It is a priority and sometimes it is at the expense of need. Need is what needs to drive the Department so maybe we can do that better. We need to figure out ways to bring in streams of money that are very flexible, get access to grant money, engage philanthropy world.

Strategic planning is an ongoing deal. To me, it is the day-to-day, grinding it out, learning from the trench to figure out how to create an intentional structure.

There are functions that we have to achieve:

- We need to deliver effective services,
- We need to know they are effective, but also see how we are performing,
- We need to have policies in place because policies determine the type of work that you do,
- All of these have to be supported openly and we need to have aggressive robust direction for the Department to increase its impact over time.

For example, we have a District Chief looking at directly operated programs within that service area. The way that we are structured right now is that they would report up to system of care, which there are multiple systems of care, which makes it confusing. We need to have consistency and uniformity. Going forward, the District Chiefs will report up to a

common Deputy who will look to make sure the resources are being deployed fairly. When there are patterns of things working or not working they are dealt with by the Department and not in silos within the Department. We want to empower our clinics and legal entities to be as effective as possible. The way we do that is by creating a structure that supports the efforts. Change is not easy, but there has been a tremendous amount of support from other Departments, CEO, and board members.

Karen Macedonio — Can you expand more on your statement or vision, of the position of the Department optimally for the future. I heard in an ideal world a single program intentionally created along the continuum with many branches so I am wondering how those two come together? Positioning the Department for the future, with the continuum of effectiveness that you have in mind, how do those two come together, what are you aiming for?

Jonathan Sherin — We are aiming for a system that is acutely responsive to the trench. Instead of doing work separately, working more together to find out what works and what doesn't. An example is improving our fidelity of our services to the needs of the communities.

Karen Macedonio — How can we focus on that intersection with the community so that we are out beyond the stigma and are interrupting the pattern before it starts?

Jonathan Sherin — I have not finished the SAAC tours due to being interrupted by a trip to DC and a family emergency. The goal was to figure out a way to get grassroots information about what is happening through SAACs here. We need to focus on to make sure that what ends up influencing the direction of the Department and the deployment of our resources is driven as much as possible by the pure need.

Karen Macedonio — Reaching into community, outside the stigma curtain so we have a tremendous knowledge of what happens because of something forensically. If we can teach people in the community. Quote from faith based advocacy: "People don't know what they don't know." They think if they are not sick, that they are well. How can we get out and raise the awareness as part of our fundamental core while we do the work in the trenches.

Jonathan Sherin — I would point to the consolidation of a prevention bureau. When I say we need to prevent stuff from happening, we need to prevent trauma, prevent the progression of untreated illness. Prevention bureau will do that across the board. Prevention bureau will take the Promotoras program and expand it to show that there is help available. SAACs are powerful conduit for information to help drive and direct where we are going.

Leticia Ximenez — As a representative of Cultural Competency Committee, one of the things we advocate for is being able to see our clients as a family. You brought up a good point regarding the systems of care. It's extremely important to see the family component, to see how each of these age groups fit into society and the family system. In order to do that we need to how they fit into their family system. It is important to see each client as part of a large community. There is importance of kinship, having family involved and supported. How will the systems of care be supporting the family structure and the community structure to be able to be drawn out into the community?

Jonathan Sherin — You take care of households, and we all need households. When we are designing programs, we need to think about the family, the lack of family, the connection to community or lack of community, basic questions that need to applied to every population that we serve. That would be the

fundamental reason to open up the whole concept of design broadly.

Sunnie Whipple — Mine is more of a question and an invitation. In regards to Native Americans and the 3 age groups, ours begin with childhood trauma through the generations from childhood to middle age groups to seniors and those haven't been addressed at all. I'd like to hear what you are talking about when you talk about critical care and level of care. If you can come to a forum. I can get all the Native Americans into one group, can you speak the way you have today and explain to them. In our circle, for some reason our entity is separate from everyone else, we don't get the luxury to hear you speak of these things. Can you address some of these things at some time, I know you are busy, but at some time would you be able to come and speak to us?

Jonathan Sherin — I would love to do that and it is a priority for me. I'm sorry that you feel that way as a community and it is not right. In terms of levels of care is true with medicine. If someone is having symptoms of chest pain, you need to figure out how to outreach and engage them, there is no stigma in chest pain, you just call 911, we cannot do that with what we do. We have to figure out a way to connect with them and depending on how severe they are, that's critical care. Level of care, refer to the fact that no matter who you are, you have potential of being real sick and coming out of the sickness. Age groups have specific needs, but so do many others that are suffering. You can say the same thing of different cultures. We know certain cultures that are suffering, and have disparities, that needs to be incorporated in the design. It means different things for different age groups, cultures, diagnosis, etc.

Richard Van Horn —With Prop 63 we got huge infusion of money, and system did not adjust. We are just a small bump in general healthcare system. Regulatory systems have really discouraged creativity; it encapsulates acres and acres of rules. If we are going to fix the system we need to peel the onion down and find the core. We also have to take on the State; it has not done well by us. Many of the community agencies have been around a long time and many times they feel like just contractors. The system calls them contract agencies and have not treated them as partners. We need to listen carefully to what you said and how as a County we can be more proactive to make things happen.

Jonathan Sherin — Thank you for your comments. The regulations are a big opportunity, for us to create regulations that are going to allow us to do a lot more of the work that needs to be done. We need to think of new ways to use resources that we have. New reinstitution, pendulum is swinging back, our conception of asylum. Jail population around the country, especially here, it is outrageous. We can play a role in rewriting the narrative going forward.

Patricia Russell — As far as the SAACs, it would be a good idea to have a stakeholders group for family members, consumers, and have conversations. Is that something that you can help us produce?

Jonathan Sherin — In order to get grassroots input, communities need to activate and organize. It is dependent on the communities to do that, in saying that, I want to assist and support that. That does not mean DMH sitting at the table making decisions, that is not the voice. A lot of time that happens because not a lot of activity to sustain conversations. The challenge is back at the community. It requires transportations for people, photocopies, bringing in consultants to help communities activate, grow and own their voice. etc. The SAACS around this County is amazing. Let's keep going.

Carmen Diaz — I work for the Department, and I do have a different perspective. I advocate and partner with parents, I am a peer parent. I understand what you are talking about. What about the natural parents? What I have seen is that there is nothing out there for us. Once we get funding it disappears or turns into something that was not agreed upon because of the funding. How do we get a wellness center support group for parents, not for TAY, not for youth, and not for adults? You send our children back to us and we have no support, training, or resources.

Jonathan Sherin — We are in process of creating wellbeing. In our clinics we will be allocating resources to create family wellbeing centers. It will involve clinician, parent family advocates, peers, etc. When we talk about the prevention bureau, they will have to recognize household and individual are critical.

Carmen Diaz — I know what you are talking about, but what I am concerned about is that it was supposed to be a parent resource center, for parents to go to. Youth and TAY are not going to the same resource center that parents are going to. Parents don't feel free talking or communication because the youth are there. There is no priority for parents; there is more priority and dialogue for foster parents, kinship, parent caregivers, etc.

Jonathan Sherin — Good point, in my mind thinking about a family wellbeing center it doesn't mean the family going at the same time and do the same thing. You may argue the fact that you have to go even at different times still creates conflict within the family. A family wellbeing center will have services to support family dynamics, support kid and support the parent independently. If it does not make sense, help us evolve it. I talk about kinship and the role of peers, in a perfect world, the role of peers that are functioning, as kin would be to work with the family to connect the family back together. This goes back to the warm handoff, which is not always so warm. Someone that lacks kin, we want them to have kin because we all need kin. The handoff should be a kinship handoff preferable to the family of origin. Kin will be working in every possible way with and individual consumer and their family, whatever it takes to reconnect them. If that means that a family member says that they need help, that peer can go to Department and say that parent needs this.

Carmen Diaz — I wasn't talking about passing from kinship to natural families. I am talking about the kids that never were removed and are with their families that have mental health issues. Parents don't know what to do; they either criminalize themselves or their children.

Jonathan Sherin — We need to think about how we are deploying our resources and being very intentional about making sure parents who are taking care of a kid will get the support they need. What kind of caregiver support programs are we delivering, are they enough and working?

Debbie Innes-Gomberg — There are a couple things in the works that will address this. There is also something that will address support for families with children in the system, particularly parents as well as parents that have adults in the system that relates to a technology program I want to talk about later in this meeting.

Legislative Update	***Susan Rajlal, Legislative Analyst, County of Los Angeles, Department of Mental Health.*** The biggest news for us is the in home supportive deal that was made at the state level. The County through their organization, CSAC all negotiated this. $598 million dollars was needed in order to transfer in home supportive services back to the County as a responsibility. In order to do that, a deal was made that the realignment growth that comes to behavioral health would all go to support in home supportive services for the first 3 years. The last 2 years, 50% of growth will go in home supportive services and 50% will go to Mental Health again. In the history of mental health - we seem to be the place they look at when money is short. We had a couple of gains; one was that the IMDs won't get an automatic cost of living. IMD rights will be frozen until we get our growth back. The CHAFFA deadline was extended for the SB 82 grants to 2021. LA County will be redesigning their SB 82 wellness grant program and it will give us a length of time to actually get the project built. **AB727** — This bill is about MHSA housing subsidies that would make it possible for anyone who is an MHSA client that is at anywhere in the continuum to retain their housing subsidy. It passed both Houses and it is at the Governor's office. They believe the Governor will sign it because it is a positive bill for everyone and doesn't take new money; it enables us to use the money as we need it. **AB1250 —** This bill will make it very difficult for the County to contract out services. Sponsored by SEIU and it will affect many of our contracts now and there is no grandfathering clause. Each time that the contract is up for renewal, the County will be under huge pressure to demonstrate having a contractor was a better decision due to cost effectiveness, or other reasons. It would mess up the system of care with more bureaucracy and more of going through the motions. It would make everything much more difficult for contractors and the Department. I urge you to look at it. **MHSA Reversion bills —** AB114 & SB908 would make the money that is subject for reversion that hasn't been collected by the state, that the counties will be held harmless through 2017 for all the funds that would have reverted. Instead if they get the plan approve by the Oversight and Accountability Commission and then they would have an extension on all of that to bump it out 3 years. That money would be put into a fund at the state level and returned to the County in the same classification it was in. This is good for the County but we are concerned because Senator Beall objected to the bill and slowed it down. He wanted all the funds to go in to the State general fund and be available for a project for schools and mental health. We need for this bill to go forward as it is written. Please call delegation members, Speaker Anthony Rendon, and Senator Kevin de Leon to push this bill forward as it is written with no changes so the money returns to the County. Voted on tomorrow so calling this afternoon is a good idea. There have been so many bills; it has been hard to get them all through. In August I will have a report on what is being passed and what it means for us.

	Marcelo Cavalheiro — I have 2 Senate bills on jail diversion for you to check out… Senate bill 8 is a pre-trial diversion, in order for you to go in to a jail diversion you have to plead guilty. Senate bill 142 is a little vague, but it talks about incentivizing community base mental health services for folks with problems with the law. It also requires mental health history be considered during sentencing. Can you find out about any savings from Prop 47? The savings from Prop 47 would bring money to jail diversion. **Susan Rajlal** — We are supportive of these two bills but Prop 47 money is totally different. The savings that can be attributed to what happens in the County, will go back to that County into fund that will be manage by the Board of Supervisors to do Mental Health Projects. **Jason Robison** — Can you tell me where the peer certification stands at state level? **Susan Rajlal** — Right now we are gathering facts. Next month I will be at the Behavioral Health Directors meeting and will try to work with them to get a consensus of that the Mental Health directors want to move this forward. Also, I will meet with Department of Health Care Services, and try to hash out some of the problems that existed before and from there we will move forward.
MHSA 3 Year Plan Implementation	***Debbie Innes-Gomberg, Ph.D., Deputy Director, County of Los Angeles, Department of Mental Health.*** In our coming meetings, we will give you an update on filling FSP slots and prevention and early intervention implementations. Dr. Sherin referenced the Department's interest in re-examining Full Service Partnership Programs and the expectations around the services that are provided to ensure that FSP programs are using the best practices and best models in approaches. We are bringing in a consultant named Sam Tsemberis who is based in New York. In 2010, he partnered with the California institute for Mental Health to develop a FSP practices scale. We are going to bring him out here to take a look at our FSP programs to look at the application of the FSP practices scale to establish fidelity. The Kick off meeting is August 11th, we will send out the Save the Date sometime this week. In the Department we have a call-in show or webinar to provide technical support. There was a suggestion to do a call-in show to answer questions about R3. We will develop a way to call in and ask questions on R3, or expansion of at risk categories, or if you had any suggestion on content, etc. **Lawrence Reyes** — Is the County working with peer advocates and also, are the counties working with stakeholders that have been pushing this certification process? **Debbie Innes-Gomberg** — Susan is working with CAMHPRO, the client organization at the state level. We will be bringing in our peer advocates, community workers, WOW workers, and peer specialists in programs. In a little bit, we will be talking about an outcome measure on "meaningful use of time." One of the ways we want to help develop it is to do a focus group involving peers in what it means for meaningful use of time. I want to hear from their perspective what it means to have meaningful use of time. There may be things we are making

assumptions on that aren't as accurate or valid as possible, so we want to bring folks into this.

I will be asking the age group leads to check in with providers next week on questions they have on Recovery, Resilience, and Reintegration, the expansion of full service partnership programs, and how the notification forms are going as far as submitting.

We have service exhibits we re-did for FSP and R3. When you see those, keep in mind this is a work in progress. We rolled the programs in to 2 basic service exhibits so it reads a little awkwardly. Refining those service exhibits and refine expectations, particularly as we move from 4 age groups to design and to delivery. We have been organized by age groups for so long we have come to develop different expectations for a common program across all 4 age groups. It's a work in progress and we will continue to work on it.

Measure 3 types of client outcomes. **Establish a culture informed by…**

- Accountability,
- Quality improvement,
- Collection and use of outcome data.
  - At the line staff level,
  - At the management level,
  - At the level of the client/family,
  - At the Mental Health plan level,
  - At the state level.

Performance at 2 levels

Client Level Outcomes

- Housing status — we want to make sure people are housed and not homeless.
- Institutional care utilization (FSP, UCC) — what is the impact of those services on going into jail, using an emergency room, going into hospital.
- Social connectedness — Idea of how connected you are to your family, friends, and to your community. As you move to recovery, you have more friends, stronger relationships, etc.
- Meaningful and productive use of time — historically we measure it with employment, education, and volunteering. The focus group of peers relates to what else can demonstrate a meaningful use of time. How does that capture.

We hope to incorporate peers in our entire system. Including the things staff do…have a peer facilitating a meeting, a peer in field-based services. Having peers follow a client throughout their care with a continuity of care.

Helena Ditko — When you are collecting information, we tend to use clinical language such as we are going to move you to a lower level of care. Consumers hear that they are getting fewer services so they resist moving to a lower level. Our language is not helpful for families and we need to look at that.

Bruce Saltzer — For the client levels outcome, they are great for the big picture. They lose meaning when we see it in the context of children such as the social connectedness and meaningful and productive use of time. I would be concerned that for client level outcomes for children we wouldn't substitute one of those for something like educational placement or function. We need to keep that in mind since some of these are not meaning for children.

> **Debbie Innes-Gomberg —** As you know, many of us struggled with trying to understand what the State is going to require in terms of an outcome measure for children that have EPSTD. We found out what it is last week and I would like to get some other providers, Kalene, TJ, and yourself to see what they are going to ask us to collect.

Marcelo Cavalheiro — In adult and older adult, I only see FSP. How do we make it system wide and continuum of care outcomes? There are some outcomes to be collected during critical care about connectedness and other stuff but we don't. We don't collect progress; we only collect outcomes on negative. Collect in critical care and follow them and have better longitude of progress. System wide outcome, not just MHSA.

> **Debbie Innes-Gomberg —** That is very helpful. We have collected outcomes by program, if we can create an approach where you collect a set of outcomes regardless of what sort of service the client is in and you can follow the progression on outcomes. I am going to take that back to them.

Lawrence Reyes — Thank you Debbie. Concerning institutional care utilization, social connectedness, meaningful and productive use of time, there seems to be a disconnect or no connection at all when it comes to navigating or engaging folks being released from institutions. As a result of that they become homeless, unhoused, or unstable. That becomes a drag on the County. I am glad that you are going to use peers in the whole system. People being released from hospitals or jails, can you partner with DHS?

> **Debbie Innes-Gomberg** — Yes, it is the role of engagement of the unengaged. One of the things the Department has struggled with particularly around transitions is the lack of engagement or connection that gets that person into a clinic. Outreach and Triage OAT is going focus on engaging the unengaged and the strategies. It is at a conceptual phase right now and the implementation of that is critical. What are the right engagement strategies that get people into care and into the right care so you can benefit from treatment and not drop out of treatment? The Department is always looking for ways to partner with the agency or aspects of the agency.

Patricia Russell — I am wondering in terms of the peers and having people work with the peers at different levels of care, when you assign someone a peer, how do you determine who would fit best with that person?

> **Debbie Innes-Gomberg** — Thank you for your comment and suggestion. It is a relationship and we are going to facilitate a relationship that we are going to have to be flexible on how to do that.

Larry Lue — In terms of social connectedness of the parents. A lot happens with how well connected the parents are to information whether they are living in isolation or stigma laden culture.

Cynthia Jackson — I have a variety of nagging concerns on how older adults are going to fit into this entire thing. You were going to convene peers, a lot of the older adults peers that engage at those meetings are the younger set of older adults. I have some concerns that we look at things like social connectedness as is realistic for somebody more frail or

homebound. Make sure you capture that group of older adults. Importance of social connectedness as it relates to preventing mental illness from happening or becoming more disabling.

Jason Robinson — One of the things we can do in our management of how we collect outcomes is to be intentional on which data we are getting from which line staff in a way that supports the integrity of the service delivery. Each person in that relationship is effective at getting different information in a way that supports the relation sip and the delivery of the service. When the peer supporter becomes the person giving all the data that undermines the peer relationship.

Provider/system level performance

Are the most in need clients being served?
Are clients staying in treatment recovering and ultimately transitioning to community supports?
Are services being delivered in the manner intended (fidelity)?

Marcelo Cavalheiro — What fidelity, whose fidelity? Sometimes folks, divisions, people comes up with a fidelity. It needs to be well documented. Here's how you do this and here is the evidence that it works.

Debbie Innes-Gomberg — Couldn't agree with you more, I mentioned the Service exhibits are a work in progress and at some point they will be as evidence based we are able to get them. It will be phased in FSP first. We will hold providers across the board to those standards and have benchmarks for the outcomes. We don't do it in a vacuum. We wouldn't do it without evidence based.

Karen Macedonio — Social connectedness, meaningful and productive use of time, and community supports, and I want us to take the blinders of here. We have a system and the system has to help people that are in need of the system. We need a universal language where people can talk to each other because we can't reintegrate, we can't recovery, and we can't have the community unless we have shared language. The language that I am hearing needs to drop the stigma, imagine that it doesn't exist and say what does it look like in a community? Think about it in a bigger picture, think about the community support, that there is no sickness and wellness, there is well being of a whole bunch in a whole bunch of places.

Debbie Innes-Gomberg — Dr. Sherin would really support what you said. We need to create a culture that well-being is expected and accepted.

Lawrence Lue — Recently came across the quality improvement work plan performance evaluation. I did not know we had to work goals around underserved population, for the two most underserved populations, API and Latino. We are at 50% of where we are should be. API for the last year that it was measured was a 2% growth rate was projected to address that 50%. The Department did not meet it, who set the goal? What are we going to do with the fact that we set a goal and we did not meet it? This brings up unmet needs, penetration rate, all the other ethnic groups were supposedly at 100% or close to their goals. Latino and Asian were half, and where do we get a chance to be part of the conversation? The report of DMH to the Board it did identify that in some of the target populations such as justice involved, homeless, APIs don't show up in that. I don't know where the conversation is and how are the goals set? It is nice to keep track of it but if you don't have a plan or goal behind it to work on it I don't know where that all goes.

	Debbie Innes-Gomberg — Good question and points. One of the venues would be here, or maybe it's the Commission, I am not sure. QI reports, and quick projects, they all need to funnel together, and they haven't in the past. The opportunity to incorporate the work that Mirtala does, the work that Naga oversees, with the board motion and with this outcome, we need to pull all these together. Steve and I talked earlier about this about the right time to bring Underserved Cultural Community work group ideas and directions to this group. I think that would foundation for the next annual update and planning process. **Romalis Taylor —** I don't see a statement that raises to the level of what we have brought to MHSA and that is cultural competency and cultural relevance of the services being provided. Some of the reasons some communities do not engage in these services is because we do not engage them in a culturally relevant way. I want to put a dot on slide: Are the services being culturally competent and relevant? I think we need to raise that level up. **Debbie Innes-Gomberg** — I have been involved in conversations around the role of cultural competency in the design process. Part of the design will be conceptual design and part of it will be operational design and implementation facilitation. Cultural competency will be essential in that process. **Romalis Taylor —** My point in that is if you don't put it on chart, it gets lost. Please raise it the mindset but putting an asterisk and highlighting that so it doesn't get lost. When you are engaging the communities and these individuals that will be part of the dialogue and discussion.
Emerging Innovation Projects	**MHSA Innovation** Innovation projects shall do one or more of the following: • Introduce a mental health practice or approach that is new to the overall mental health system • Make a change to an existing practice in the field of mental health, including an application to a different population • Apply to the mental health system a promising community-driven practice that has been successful in non-mental health contexts. Primary purpose of an innovation project. • Increase access to mental health services • Increase the quality of mental health services • Promote interagency and community collaboration related to mental health services or supports or outcomes Innovation 1 & 2 INN1- Integrated Care models INN 2- Community Capacity building for the Prevention of early detection of trauma **The Potential of MHSA Innovation** The MHSOAC's Innovation Summit • MHSOAC- novel access strategies • Partnership development

Convening at Google Verily

- 10x thinking
  - 10 fold greater solution
  - Technology solutions applied to mental health.

Innovation on the Horizon

Increasing access to Mental Health Services and Supports through technology

Technology- mental health partnership supporting:

- Peer support through chatting
- Family support through chatting
- Virtual communities of support
- Virtual cognitive behavioral and other interventions
- Digital phenotyping (pattern in how fast you type or change in voice, etc. to have a pop up intervention)
- Referral to mental health series where needed.

Accessed through DMH website, computers and smart phones:

- Partner with schools, colleges, NAMI, and other strategic access points.

Carmen Diaz — When you are peer, you want that connection, you want that engagement, you are not going to get that through technology. You won't get that same connection going to a parent's home, sitting down with them, understanding and talking to them. I don't understand how this is better or will work when you are support a family or peer through a computer.

> **Debbie Innes-Gomberg** — This isn't in place of anything, it is part of a solution. This is not going to work for every individual, and for every individual of certain ages. This is a part of a solution that has shown great promise outside of the Mental Health arena.

Emma Oshagan — One of the things that worries me about technology is in a lot of the communities, a lot of them do not have computers, especially the older generations. They do not have Facebook, or even computers, what are we going to do with that population?

> **Debbie Innes-Gomberg** — It is a great opportunity to bring in our library partners. Peer resource center has computers. We have to increase access to the internet and to be able to do these things and those are the two examples on how we can do it.

Cynthia Jackson — This is super exciting, and I think one of the components that are necessary to make it meaningful for people is to not just a virtual chat room or like Facebook. The ability to be face to face, so the video chat would be good. I completely agree with Emma, the biggest barrier we find is lack of access. Our IT guy is trying to get free tablets that are simple to use and also working on internet access issue. Skype for business is HIPPA compliant, if you can do that, it is a whole different interaction and meaning and not some random virtual thing.

Debbie Innes-Gomberg — I know that it is anonymous, and many of the companies that we have surveyed, it is anonymous, is there a visual feature on any of them?

Ivy Levin - It is something that we are going to explore. For the most part, there is not currently a visual. The platform hat we are considering has some opportunity. There has been lots of research about tela-therapy and using technology in a variety of different ways. We will leverage some of that research, what's been done and out there and construct something that makes sense for DMH.

Cynthia Jackson — If you want a committee or anyone to help, we have really been trying to work on this.

Mariko Kahn — In Innovation 1, one of the lessons we learned is how individualized the approaches had to be. This is going to be another example of that. For TAY, it will probably be a positive thing. For API, for Koreans and Chinese, they will love it because they are already so into that with the smartphones but it will not work with some of the other populations. We are trying to solve the world's problems you are trying to find some different techniques.

Debbie Innes-Gomberg — Yes, absolutely.

Jason Robison — There are a lot of great components here. I think the frame for this is how do we use technology to further our connections and efforts. There could be a way to use that app to also connect people to existing self-help support groups That gives them the face to face interaction and on the back in a way for people to track their progress, which helps meet our outcomes and data need.

Debbie Innes-Gomberg — I will get to that more in a moment. That is a very compelling interest.

Richard Van Horn — The reason the OAC said we wanted to do this Innovation summit is that we realized that many programs are coming through for innovation dollars are at the very best called innovation light. They are minor tweaks, different programs; we aren't really moving the ball down the field as it were. You have to recognize the level of challenge this is, we are spending approximately 100 million dollars a year on innovation that is a lot of cash. It is going out on the same formula that distributes to the counties, which also has problems since the smaller counties get less and the bigger counties getting more money. There has not been a push on inter-County collaboration, which is going to be happening, it is setting up to look at immense problems. There are huge problem in what is breaking new ground.

Karen Macedonio – Inter-county collaboration, the ideal place is Antelope Valley, we have two counties, we have a huge population, and we have need for technologies. Beyond that technology, two words that may not be understood by the staff at DMH, Obama Phone and YouTube channel. Obama phone where you get the pop up tents and you get a free phone, but if you have not need to see those you pass by it and don't realize it. There are a whole lot of people with technology in their pockets that don't know how to use it. The YouTube channel that a County employee cannot access because of the security requirements. If you had small micro learning recording that is anonymous and the phone can access it and then there could be some place to call to chat or connect to a self-help group.

Marcelo Cavalheiro —Common Ground is a consumer run organization run by Patricia Diggins. It has everything you mention above. Peer support through chatting, videos, etc.

Technology Innovation Goals

- Increasing access to mental health services and supports

- Broadening the array of services available
- Reducing the stigma associated with traditional mental illness seeking
- Reducing the tie to recognition

Innovation on the Horizon

- Utilizing passive data to engage, intervene, and reduce the duration of untreated or under-treated mental illness
- Technology to inform relapse prevention.

Karen Macedonio — Back to your statement of the need to create a culture that well-being is expected. On the last two slides you were looking at the expectation of an illness, I would really like to see that balance as well being is expected. We are reaching into the technology to raise awareness that well-being is something we need to work on, and if there is a barrier to wellbeing, there are resources that can meet the needs to get you back to the pathway of well being.

Patricia Russell — If you want to use technology to help people, get it high quality. I am worried about if you have someone already paranoid and there is algorithm, how will this affect them?

Debbie Innes-Gomberg — It is an individual choice. Your point is a good one and the Department would want to weigh this. The organizations we talked to have been very mindful of this. Their products are very attentive to these sorts of things.

Tony Leggitt — It seems to me there is a major challenge with people in Department not being able to use Facebook or any of these applications where this stuff will be. How do you propose to deal with that?

Debbie Innes-Gomberg — The employees of the Department would not be the users of these products. If they are trying to interact with staff, but that would be accessed through a different channel, the client portal. The main driver of this would be individuals that access the internet in a non DMH setting or work with CIOB, we want to make sure it would be easy to access.

Emma Oshagan — Will there be a period of training for clients to learn how to use the technology?

Debbie Innes-Gomberg — Absolutely. If we were working with schools, then we would work with school administrators, or appropriate level to make this service available and to provide education. I can imagine visual campaign around this service. When we put this on our website this would be front and center on our website.

Leticia Ximenez — This is a great idea as a supplement, as an addition to what we are already doing to make sure we access other people that were not able to access. I am sure you have already thought of the threshold languages. With the internet and all of these different technologies it would be easy to do different applications and to make sure different people that speak Korean or Chinese, etc. that they can access those applications in their own language. It is important to make sure as we are doing this, to make sure the people are getting the technology and that the training is there on how to use it and when to use it. Maybe we can tap into grants on getting clients a phone, smart phone or iPad to use.

Debbie Innes-Gomberg — One of the companies we talked to said they have over 140 languages.

Richard Van Horn — Dr. Sherin more interested in wellbeing. 50 nations developing emotional wellbeing as a target goal in public health. Group of scholars who also been targeting around emotional wellbeing. There is a lot of focus on emotional wellbeing. UCLA seek community partners and care, which is aimed at emotional wellbeing and how we look at neighborhoods. The key partners in this are not only the OAC but also the Healthy African American families, which has been a major driver. Various nations have started emotional wellbeing as key outcome in their public health models.

Marcelo Cavalheiro — For immigrant folks, 'WhatsApp' is common, especially to communicate with other countries. It is a way of free communication. They have self-help groups. This is a way to tap into the immigrant group. Immigrants still have families back home and that is how they communicate with them.

Peer Operated FSP

- Make a change to an existing practice in the field of mental health, including an application to a different population
- Purpose: increase the quality of mental health services
- Details:
    - Peer staff
    - Licensed supervisor
    - Psychiatrist

Marcelo Cavalheiro — The Atlas program in Service Area 7 has every staff member who is a person with lived experience. They either were homelessness, addicted, incarcerated, etc.

Debbie Innes-Gomberg —The feedback is that it is a good idea. Based on Marcelo's comment, can we still in your eyes move forward with it?

Richard Van Horn — Just because it is tried once, does not stop being from being an innovation until it is tried a few times and we have a success measures on it. Innovation grants are 5 years, so you have some time to work out the kinks. Several licensed psychiatrists are also peers.

Jason Robison — Yes, I think it is a good idea. Innovation is also building on an existing model. When we did first round of innovation, the Prism program, we thought of that as "FSP-lite." It was peer-driven and what we did with the psychiatrist component was to not have them be on staff. They used psychiatrists to refer to the program and that saves cost because psychiatrist won't be on staff.

Sunnie Whipple — This is going back to the Native American. I myself, as a consumer, have not connected with a peer staff, I cannot find one. There are licensed supervisors and psychiatrists but since I am off reservation, I have been here 30 years, but the way I grew up and my worldview is different. With PTSD I have a hard time finding any peers within DMH to talk to. They find me more fascinating me telling my stories that they are in helping me.

Leticia Ximenez — It is a great idea. Having something like this we need the support, training, and ongoing support as a whole. As you were talking about it, we had a presentation that had sober living housing on how they would use

peers, and it was extremely helpful and effective. People really resonated with it and they had good outcomes. Making sure peer stuff is culturally competent, and that there is a lot of training and support.

Debbie Innes-Gomberg — Thank you. I forgot to mention that I am asking my staff to really look at recommending a training protocol and certification process. This will be absolutely critical; this is the first time we have proposed doing this so we want to make sure we are doing the right thing.

Karen Macedonio — I want to ask you to go back to what you presented about 10x thinking, because when you got to this part I felt all of us really want peer operated, peer involvement but that is something we can accomplish, not something we haven't thought of accomplishing. Can you apply that lesson of 10x thinking to the peer operated FSP would like to see what ideas we can come up with?

Debbie Innes-Gomberg — Great idea, I know this is not 10x thinking. It is the more traditional use of, at least in Los Angeles, around where we want to go and how to test that out. We would really like to see peers run our entire organization and system of care, we have to think very carefully and thoughtfully on how we do that so that it is successful and we can support them.

PEI on the Horizon

First break and early psychosis

- Entry portals
  - Hospitals
  - Schools
  - Families
  - Juvenile justice facilities
  - Interventions
- Supportive services

Employment support

Housing

PEI on the Horizon

- Trauma-informed care
- Risk factors for trauma
- Interventions
- Portals- hubs.

Patricia Russell — In terms of housing, is DMH working with Phil and Sal on an ongoing basis? Let's face it, we do not have housing. Is someone looking for vacant buildings to look for good sites?

Debbie Innes-Gomberg — Maria Funk would be the person to report that to. As we start to implement HHH and the services associated with that and eventually No Place like Home, we will have her come out and talk about the work that she is doing.

Paco Retana — A comment of trauma informed care is a great idea, as this is being rolled out and people began to unpack this let's make sure staff are included in the trauma informed care process. A lot of our staff also experience a

	lot of vicarious trauma with working with the clients so we need to include that in the discussion and dialogues.
Public Comment and Announcements	**Lorne Leach** — Regarding Social Connectedness---Things are implemented, but provider replaces it. We need to use our 5 senses; it makes a big difference. My concern is that people will take it and run with it and make it something else. Culturally competent and the language. When you are talking about peers even though I am here participating in this, I still do not feel including because you do not use parent peers. Families are separate, peers that work with peers are separate, us we have our own culture and perspective on how we work as a parent-to-parent piece and caregivers, and it is totally different. Please use parent peer terms. 0-18 and older, you will lose children again. Fear that we will lose the parent/children voice. Carmen has a lot to say, we need to look at that, and respect that. **Mark Karmatz** – There is a program that helps people stay out of prison. Job opportunities. **Wendy Cabil** — SAAC1 Co-Chair. This is a wonderful advertisement for the family resources that opened up in Palmdale (holds up a flyer from LA Care). I didn't know about it, I didn't see any flyers, and disappointed that people weren't talking about. I did find this Lifestyle magazine at a healthcare facility - usually you have to pay for these magazines. I want to encourage better communication and look forward to bringing feedback in the future. I don't expect all my questions be answered. I want to make sure I have an understanding and clarity of what unserved and underserved means, I didn't want to assume and what is the source of these definitions, how are these two terms different? What is the process for identifying populations as being unserved or underserved? How are the success measured in serving the needs of unserved and underserved populations. Where can I see the data related to unserved and underserved populations? Are barriers or challenges included in that and what is the plan to address these challenges or barriers? **Adjourned**: 12:24pm.