COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, July 16, 2014 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 updates on the proposed MHSA Innovation 2 projects.
2. Review and discuss the principles for the MHSA Innovation 2 planning process.
3. Hear an update of key points from the SLT Standing Committee's July 14, 2014 meeting.
4. Review, discuss and adopt Health Neighborhoods as an organizing framework MHSA Innovation 2 projects.
5. Continue refining and developing the MHSA Innovation 2 proposals.
6. Agree on next steps.

MEETING NOTES

MHSA Innovation Updates	**A.** We want to review and approve the principles or agreements for this round of MHSA Innovation projects. We have 5 principles. As the planning process unfolds we may add more principles. **B.** First, we want to serve all of age groups. Once identifying all innovation projects, as a batch, we want to ensure that they address all age groups. In the first round of innovation projects all age groups were served but adults were the primary focus. **C.** Second, once submitted the proposals from your organizations no longer belong to you. The content now belongs to the entire SLT group and ultimately the Department. The group will review the content, compare it to others, and engage in best thinking around that content. Your proposals are input to the process that will help others develop ideas for innovations projects. **D.** Third, the SLT and the standing committee have the liberty and power to refine, change, modify, and/or combine projects, particularly the learning questions. Sometimes projects have the same learning questions, therefore it makes sense to combine the projects. If there is confusion please ask questions or clarifications. As we refine, combine, and change things we may find ourselves in these moments of, "What is going on here?" **E.** Fourth, is conflict of interest; it is everybody's responsibility to regulate for conflict of interest. We are walking in here with an interest to improve mental health outcomes and the lives of folks and families, etc. but then we may have a conflict of interest on a project that we submitted. **F.** If your organization wrote the proposal be aware of the potential conflict of interest as you engage in discussions. You should not try to hold onto the idea because it positions you best for that project. If we notice somebody struggle with conflict of interest, we may need to help regulate that.

	G. Finally, as we go through our discussions, and conflicts and tensions emerge, it is important to remember that we are all responsible for continuing to reduce those disparities for unserved, underserved, inappropriately served individuals, and communities. These are the 5 agreements that we came up with and that were endorsed in the SLT standing committee. **H.** For SLT members would anybody like to oppose 1 or more of these or are you okay? **I.** Nobody blocked the vote. **The principles were accepted by the SLT.**
MHSA Innovations Planning	***Rigo's Presentation on Health Neighborhoods will be emailed to the SLT.* **Sam Chan Presentation:** **A.** We need to join in creating fields of belonging where healing environments, and healthy groups, families, communities, and organizations cultivate healthy individuals who, in return, contribute their best selves to the group. This collective endeavor, is about creating intentional communities where members are nurtured and valued, where information flows freely, and there is healthy interaction among all groups and institutions support the growth and development of all. **B.** We want to improve the well being of all by sustaining creative supportive living connections and environments that strengthens connectedness between people's strength and recovery from illness and competence and resilience in individuals and communities. Resilience refers to a combination of a cross-cultural view and definition of resilience that discusses the extent to which individuals have safe attachment, ties to friends and larger networks, community institutions. It includes their own skills, including: social skills, the ability to help somebody, be of value, and have strength from experiences and challenges on to a sense of coherence and meaning in their lives along with their own values, sense of identity, friendships, solidarity with others, and especially faith, fellowship, and a spiritual connection as well. In the children's world we need to talk about strengthening families and protective factors. **C.** When promoting mental health and a health neighborhood the concept of protective factors is critical. In the Hmong community in northern California, they have a cultural center that is developing protective factors that align with the Hmong culture and provide strategies for families to promote protective factors like social connections, concrete support in times of need, parental resilience, and working with an ethnic specific population to see how traditional values align with acculturation process. **D.** In the bay area Mark Bynoff formed a coalition of tech companies where he challenged 20 companies to pledge a combined $10 million to fight poverty in the bay area. They are trying to pull donations from multiple large tech companies and reach 2000 companies that would commit at the level of at least $500,000. It is a philanthropic combined effort to focus strategies and funds. **E.** We use some of those same elements here in L.A. in the partnership for early childhood investment which includes about 35 philanthropic organizations, First 5 LA, California Endowment, family foundations, all pooling funds to focus on children, birth to 5. The group looks at investments that target, based on this logic model, concepts, innovation, and

innovative programs that advocate or address early childhood systems change, communication in the use of media to promote messages to the larger public and leadership. Those are already in place and moving forward.

F. We have a 1-year timeline for these innovation grants and proposals. We need to be practical in our small group activity, zero in on some of the 20-30 different proposals and highlight what the critical commonalities, identify the priority issues. We moved from the healthcare reform called "treat to target" which is to, "identify a specific problem, find the best intervention, and treat that as the priority problem."

G. We looked at treating target populations, target the most pressing issues and contributing factors upstream that lead to some of the problems in the target populations. Among the primary target populations in the TAY and child populations are medically fragile infants and their families, children with developmental disorders including autism spectrum disorders and children with special healthcare needs, chronic needs and with co-occurring mental health needs, parents, and caregivers, relative caregivers, grandparents, huge population as it ties with the foster care child welfare system or the general population. We looked at family resource centers, family empowerment centers, parent education leadership, and also had high risk populations of pregnant parenting teens, middle school children, children in any population that is in transition; always a higher risk population.

H. Ultimately, we looked at ethnic communities, focusing on unaccompanied minors. Many at the border were coming in as unaccompanied minors, Honduras and El Salvador in particular, are being driven by former gang members, who served time in jail being returned and deported back to the country of origin and now displacing the minors to get away from what is going on culturally within those communities in the country. It is a full cycle.

I. We also looked at pre natal, perinatal, healthcare, and mothers who are pregnant. Finally, faith communities and our partnership with clergy.

J. We then started moving upstream to figure out among these different groups what some of the care pathways in which families, once identified, come into the system. What are some alternative strategies for supporting individuals and families before they enter the formal mental health or other human services systems? Once in, what are the ways we integrate? Who are the agents of change and caretakers at the community level? That is where the actual nature of these proposals started moving toward family health literacy, promoting education, the general public, as well as sub groups of families including early head start, early care education, every possible gateway for promoting health and mental health literacy.

K. We looked at early care and education providers and birth to 5 as a critical area to promote a larger public awareness and for true prevention campaigns. We also know the child welfare population, the blue ribbon commission, directives and where we are going to align those efforts, beg for much greater interdisciplinary, transdisciplinary work across professionals, but also focus on larger community engagement.

L. We distilled down these proposals into these core concepts that think out of the box. This new way of thinking goes back to, "What in that history contributed to some of the issues they are currently struggling with on a social level? Who do you

systematically partner with to help address those issues rather than live in your world of intervention later down the stream?"

FEEDBACK

1. **Comment:** Two things --one is that it is not poverty per say. It is a lack of control that people feel in these communities that poverty induces. You can look countries in poverty and they have the life expectancy that we do or better. So it is not poverty per say but it is the organization of human relations in these communities.
    a. **Response**: One is that the proxy that income represents is really the failure of educational systems because you boost income with education. That always makes the conversation confusing because you think, "Oh well if we just change the education..." but that is a long-term prospect. So what do you do in the meantime?

    b. **Response**: "What are the key issues that we can attend to that will have the biggest impact beyond poverty directly?" We have to deal with poverty through education. That is the main determinant. The other major thing that we need to work on is community strengthening, in connecting the dots and building the capacities of communities.

2. **Comment:** Regarding data collection up front. We need to honor that in this process. Those who want to bid on the proposal collect that data, analyze that data, and make sure that they use it for decision making on how to improve the process.

3. **Comment:** Just remember that the classic definition of empowerment is a process by which individuals and communities gain mastery over the conditions of their life. Lack of control is the opposite of empowerment.

4. **Question:** "What are the constraints on what we are doing here today?" Secondly, in terms of another constraint, this is just not any MHSA money, this is innovation money, and there are some big players in this game who have done this work for several years. How are we going to take our pot of money and play in this big arena in an effective way that actually impacts the intents of the MHSA?

5. **Question:** These constraints--we can turn them into all learning questions. What is the right player to work with? How much is too much? What is the right middle ground? What is the right sandbox? Those are all questions that are unanswered in this field.

6. **Comment:** The oversight commission will determine what is truly innovation and what needs to be explored. The field is wide open in terms of population-based issues. We have not looked at that. We have not done well.

7. **Comment:** The evaluation of this second round if innovative will be exceedingly important because it will tell us if we are on the right track.

8. **Comment:** SAMHSA is looking at, “What about aggressive outreach? How do we really reach out the most difficult to find?

How do we answer the folks who are pushing involuntary outpatient commitment and does this actually do any good or does it change anything?" We have a lot of answers to get. This is going to be critically important.

9. Comment: There are studies of population based health issues and community issues but we have not done this in terms of the health system. It is an entirely new application. We must make sure these innovative programs truly innovate and help us chart new territory.

10. Comment: I am glad we are trying to find an overarching framework by which we approach innovations funding.
    a. Response: The standing committee group looked for the underlying factors for why certain conditions persist in a community. We wanted to find a framework that allows flexibility and innovation for different agencies and groups to collaborate together and find some solutions.

    b. Response: The other aspect that we might look at is how trauma affects your community. That includes the symptoms or diagnoses such as depression. But if we look at our immigrant populations, if we look at our homeless populations, if we look at our communities who have drive-by shootings, violence in the schools, all of that inflicts a level of trauma.

11. Comment: I am for health neighborhoods. The concern is over emphasizing poverty and health neighborhoods. Important not to forget that there are resources that are not available for cultural populations; like mental health resources for example, appropriate language, treatment and so on. They do not exist for some of the underserved and cultural populations. I think we need to take that into consideration when we are talking about health neighborhoods or about poverty.

12. Comment: the average doctor does not know about the concept of tying stuff together. That needs, in my view, to happen. Project Return brought Gabriela Grant, Director of the Center for trauma informed care in Santa Cruz. They did a thing called trauma informed services, creating physically and emotionally safe programs for trauma exposed populations.

13. Comment: We were talking about innovations and health neighborhoods. I have not heard anything about partnering with local businesses. A lot of times we talk about mental health and educating people. But people sometimes are not mentally ill. Local businesses, jobs, people get desperate because there is a lack of resources; lack of resources and jobs in the community, so what happens? People do not want to hire--sometimes it is because of that stigma. They do not want to hire because they do not trust people. An opportunity in a neighborhood and I think partnering with local businesses is crucial.
    Response: A health neighborhood approach does allow you, through a community partnership, to link with business, but again the question will be, "In what way will that translate into better mental health outcomes?" Your thought does fit within a health neighborhood piece but that would mean addressing the question that Jim asked. What are the sectors that we want to work with?

14. Comment: This is a great concept. I am presuming that this health neighborhood concept does not exclude other

innovations ideas.

Response: Exactly. What we are going to ask you to do is adopt the health neighborhood framework. However, if there is an innovation project that does not fit we will still consider it on its own merits. This helps us at least have a common conversation across the proposed projects because from a ground up process when you looked at those proposals they seemed to all be flowing under a health neighborhood.

15. **Comment:** My comment is on ensuring that we are covering all under represented or underserved that, from a geographic standpoint, I know that there is a lot emphasis in place based interventions but I think many communities, particularly in API and LGBT communities, they are really spread out countywide.

    Response: The proposal is to adopt a health neighborhood approach that we can start guiding the development of innovations projects but there are two expectations. One is if the project just does not fit but secondly we still do not know how to approach countywide populations. We do not want to exclude them.

16. **Comment:** I participated in the standing committee meeting on Monday, and then watching what is happening today I am just blown away by the evolution in 2 days. We have health disparities. Now we have health inequities. We have to address both. It is not one or the other. I think the part that is my favorite sentence so far is your classic definition of empowerment: the process by which mastery over the conditions of life is regained. That is mental health.

17. **Question:** At what point will other innovative programs, new ones that are not on this log, have an opportunity to be looked at within the framework of the healthy neighbor concept?
    a. **Response:** The 31 proposals as well as the summary of those proposals are getting us to the point where we are at right now. In our standing work group on Monday we acknowledged that many of those proposals will evolve. Some will meld together. Some will not be prioritized. The work groups that we are going to start to get into will then inform all of the next steps.

18. **Comment:** Would it be fair to say that we are not accepting new proposals? What we are encouraging is creative thinking on what we have. Participation from this point forward is really crucial because your ideas can help.

19. **Comment:** This is the time for us to reach out to those not in the system, those coming into the system, the inappropriately served, the under-served and those not served. When you are trying to make logic out of illogical situations you have to count in factors that individuals have been wounded for 2 to 3 generations.

20. **Comment:** I represent the faith community. I do faith based support of children with autism and their families. I want to go back to a comment about speaking the language. Sometimes there is a perception within the faith based community that DMH rolls in with a lot of great ideas, does a little bit and rolls out again, and that there is not an adequate appreciation and respect for those of us who are in there doing this work, oftentimes first providers. Faith based communities represent a level of infrastructure that far exceeds anything that DMH will ever have. It is an untapped resource. There has not been an adequate effort to really support the faith based communities with real dollars. It is great to have your connections. I see that on these proposals there are 2, 4A and 4B, faith based entities. I would like to suggest every single one of these proposals is faith based. Every single one needs to be viewed--do not pigeon hole us

into this one program--but look to see how we can enhance and inform all of your programs because that is what we are here to do.

a. **Response:** Thank you for that. These 31 proposals were developed a little bit in a vacuum. To the degree that our funding streams allow us to not do this we do not want to just give money to entity 'A.' We do not just want to give money to entity 'B.' What we want to be able to do is create a network of services that support one another in support of mental health recovery. How we do that is really going to be largely up to many of you as to how that happens and how creative we can get.

b. **Response:** If you adopt the health neighborhood framework, you could say we are going to invest in understanding the extent to which the involvement of the faith based community in a neighborhood actually contributes to better overall mental health for the neighborhood.

21. **Comment:** I am a consumer. When I think about healthy neighborhoods in a framework, is education. If we do not know what the problem is there is no solution. Then in the clinics, what is really happening, there are family members who are also present. Instead of television, we should have information that would educate us about depression, anxiety, and stress or whatever the case might be. We need to be educated about what it is that we suffer from.
    Response: Thank you. We want this to trickle down to the level of the individual and our neighborhood so that stuff just does not happen over us but really gets to our everyday life.

22. **Comment:** We began the discussion with Bill Vegas' comment about the control issue being at the core of poverty. It is the issue of social isolation; 1 in 4 Americans having no one to confide in. Out of 750,000 kids, birth to 5 in LA, 4 out of 10 are in poverty. Some of the thinking that undergirds the flow of this conversation; the notion of being wounded in our communities. Mental health is everybody's business. As we build a community and fields of belonging our challenge is creating language of connection that not only allows the groups that do not fit into the health neighborhoods to belong conceptually but also to belong socially and spiritually.

23. **Comment:** There are going to be more iterations of us clarifying the framework. If the project does not fit into the framework we will consider it on its own two feet. Innovation projects can also serve populations that are geographically dispersed but again if they are not then we will figure it out.

24. **Comment**: We have consensus so we are moving forward with the health neighborhood framework.

VOTE
22 Strongly Support
12 Support
5 Support with Reservations

Feedback: Health Neighborhood Concerns

A. **Question:** How do you establish trust within the partnership? Are we looking at local grassroots, Community-based

organizations, who have the pulse in the community with the health neighborhood?

B. **Question:** What are the targets of change? How do you believe that change can be brought about?

C. **Question:** Is there some sort of formal infrastructure that defines and supports those neighborhoods that you displayed that DMH might be able to interact with or is that still on the drawing board?
   a. **Response:** Yes.

D. **Comment:** We to make sure that we understand that when they say 'everyone' they also mean children. Adults have voices and often children do not have voices. Just make sure that there will not be disparities within a health neighborhood.

E. **Comment:** In terms of health neighborhoods--the challenge of it being geographic. To permeate across these neighborhoods you do have to have recognized communities of interest or commonality. Secondly, I think what has never been challenged is, "How are we really going to incorporate this strategy with Best Start, California Endowment, and California Community Foundation?" The challenge for us is, "Can we glue all of these together and better utilize those resources and leverage them rather than actually avoid them--saying well they'll take care of it and we will do this--how do we become complimentary?" When you get down to these organizations they all have regulatory limits. Where I've seen these things fail is that you get down to the grassroots, the bottom level, and all of the organizations say, "I've got a limit." And they wonder why the state and county did not free us up to do this.

F. **Question:** How do you define residence? Is that going to include individuals who do not have an address but might be still residing in the community? The second issue is that you need to also include parks and recreation department and people to provide recreational opportunities within the community.

G. **Question:** How are we going to protect countywide populations? Some do not fit in a geographical framework.

H. **Question:** In the strategies discussed, is need assessment one of them? There are communities that do not have resources. If we implement the concept of health neighborhoods then we need to find out, "What are the resources we need to do need assessment?"
   Response: Let's name the question around the extent to which an inventory of needs and assets will be part of a health neighborhood approach as we look at different populations.

I. **Comment:** I want to second, third, and fourth what has been said about countywide populations, both ethnic and specialized, and how we are going to make sure we look at--we create an exhaustive list. Using a geographic model, how do we make sure that it is a culturally competent model and that there are measures to ensure that they are culturally competent for all of the populations?
   Response: “Health neighborhoods” is one approach. There is also "health communities" that focus on communities of interest or shared identity or communities that are experiencing similar sets of conditions even though they are not clustered geographically. There are ways we can play around with that concept and

	see if it works.
Public Comments	A. **Announcement**: Project Return is doing a training for certified peer recovery specialists starting on October 13th B. **Announcement**: Alternatives Conference is Oct 23-26: Carib Royale Hotel in Orlando. Rising registration costs as date becomes closer. C. **Announcement**: African American veteran training at Culver City Veterans on August 2nd. Free. D. **Announcement**: Friday in Huntington Park: Project Return picnic. E. **Announcement**: NAMI California 2014 annual conference in Newport Beach, August 1st and 2nd.