COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH

System Leadership Team (SLT) MEETING
Wednesday, August 20, 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 an update from the County of Los Angeles Department of Mental Health.
2. Inform the SLT about State budget, legislative, and related issues.
3. Provide updates on the MHSA Innovation planning process and continue developing MHSA Innovation proposals using a Health Neighborhood approach.
4. Agree on next steps.

MEETING NOTES

Department of Mental Health - Update	*Marvin J. Southard, Director*, County of Los Angeles, Department of Mental Health A. **Implementation of the Affordable Care Act.** Implementation will be done in an integrated fashion using the Health Neighborhoods, creating more than a consortium of providers but a community empowerment strategy. Academic partners are working to submit several grant requests. The National Institute for Mental Health grant will use the Health Neighborhoods concept to overcome disparities in health outcomes for minority communities will be submitted in November. This is part of the LA County strategic plan so the Department of Publics Health and the Department of Health Services are also involved. B. **Health Neighborhoods**. The department is focusing implementation initially on the five communities of Boyle Heights, Watts-Willowbrook, Panorama City/Pacoima, Lancaster and Long Beach. These communities are a starting point and may be expanded to 25 communities across the county. Development will also go forward as opportunities arise in other communities and as communities self identify. The thinking is that is a good to start to focus on places where there is already a community infrastructure in place that can support the development of a Health Neighborhood. The goal in all of this is not to reinvent wheels or to come in as outsiders but to build on what the community already has in place. We are building, what we call the "little h, little n" in these five communities, this is the consortium or coalition of mental health and substance abuse providers that will share information about common cases in that area. The initial outreach is particularly focused on faith communities because there are already efforts going in the five initial areas that can be connected. The initial five areas and many of the additional 20 places already have collaboratives in place through other place-based initiatives (First 5 LA's Best Start and The California Endowment's Building Healthy Communities). We are going to build on those infrastructures, not replicate them. It will be a wonderful but exhausting challenge putting everything in place because there are a lot of working pieces involved. C. **Jails and Diversion.** Meeting this coming Monday, August 25th with the Department of Justice to discuss the progress

within the jails. DMH approached the District Attorney (DA) some time ago to see if we could do something about diverting people with mental illness from the justice system and the District Attorney has been very willing to take a leadership role in engaging the legal community, particularly the courts in ways that the mental health system, by itself, could never do. So we have had a process that many in this room have participated in that was sponsored by the DA and involved the GAINS center from back east. The DA's draft of diversion expansion plan, created with stakeholders and involved the GAINS center, recognized many of the things DMH already has in place and will give suggestions on how to expand those in a systematic way. The biggest piece of that expansion, if we can manage it, will be the pre-booking diversion so we can prevent people with mental illness from ever being arrested in the ways that they do in Miami Dade and in San Antonio, Texas. Representatives from San Antonio are coming to the substance abuse and mental health conference in October and are presenting on their diversion process. Dr. Shea and LA Sheriff's personnel have also been to San Antonio to look at the processes that they have in place there and see what might be duplicated here. The biggest difficulty in replicating their strategies are really the law enforcement training piece because there are so many law enforcement jurisdictions here in LA County and San Antonio has just a couple.

D. **Expansion of Laura's Law**. The Board of Supervisors passed the resolution to implement Laura's Law in LA County about 10 years ago and it has been changing and adapting through the years to meet the various circumstances that LA County has faced. The recent clarifications by the legislature on spending and other pieces of the law have given the Board of Supervisors the opportunity to look at the expansion plan which went through a one-year stakeholder engagement mini process. There is a request for proposals because the expansion of services will be done by the nonprofits providing the Full Service Partnership (FSP) programs that are the core of what will be done in that program. Laura's Law as we see it is primarily an outreach and engagement tool rather than a treatment tool. We see that as one more way of engaging people who may be reluctant to seek services.

E. **Katie A.** There is a need to expand the services that DMH provides to foster youth. Los Angeles is, by far, the furthest advanced in the implementation of the kind of reforms that the Katie A. lawsuit requires. There are still further adjustments that need to be made and DMH, in partnership with the Department of Children and Family Services, are looking at the additional adjustments and working to identify additional funds that will be necessary to expand Early Periodic Screening, Diagnosis and Treatment (EPSDT) to provide the additional services so that we can move forward.

F. **Access Issues and Audit.** The biggest challenge that our system is facing right now is ensuring timely access to services. The Veteran's Affairs Department has been in the news recently for this same issue. An audit is being conducted on the health Medicaid program here in California concerning access to care. On the physical health side in California the Affordable Care Act added a lot new participants but the Governor reduced the rates by which providers were paid. This combination of more demand and fewer providers means there are difficulties in accessing care. The audit is meant to quantify how that lack of access is playing out in California. That particular audit is not currently aimed at the mental health side of Medicaid, but it will be. Dr. Shaner is leading an effort to look at how we get a handle on the levels of care that people need so we can make sure people get access to the appropriate care given their illness. The Department of Mental Health is working with the provider community as well as other Los Angeles County Departments to quantify the effects of providing appropriate levels of care. The challenge is that we are going to be measured with expectations about how people receive access to care in the Medicaid program. The access standard is the time period, tentatively 15

days, from when somebody tries to access care (either by walking in, by calling the access line, or other forms of initiating the care process) and the time they get a mental health assessment by a licensed practitioner. Adjustments need to be made to reach that goal. There will also be a metric on the amount of time it takes for patients who need medication from the time that it is identified they need medication to the time that they have their psychiatry appointment, this time period is not clear yet. Counties and providers will be measured by these metrics. The realignment allocations work group for the county of mental health and substance abuse directors came up with a principle for the allocations. The first principle was a base year, most likely 2013-14. No county will get less than it got in the base year with any growth beyond that allocated first to entitlements. This means that what a county spent in the previous year to meet the needs of an entitlement program will be privileged in the distribution of growth. Insofar as we spend our money to meet the entitlement needs of Early Periodic Screening, Diagnosis and Treatment, ultimately it will also affect the managed care allocation which is our inpatient costs. It will also eventually apply to drug Medicaid, because the drug Medicaid program is in some disarray at this moment and it is not able to spend what it has, much less move toward growth.

FEEDBACK

1. **Question:** Regarding access to care, will this apply both for Los Angeles County operated and contract facilities? It has been my experience that when someone tries to access services, whether it is Los Angeles County operated or contracted facilities, around the month of March they say there are no openings until the next fiscal year. Will that be taken into account?

   Response: Yes, it needs to apply to both Los Angeles County operated and contracted facilities--any Medicaid provider. If you are handling Medicaid you need to meet these guidelines. Running out of money at the end of the fiscal year cannot be an excuse. It will be handled in two ways: first, we need to be able to expand the allocation. The second way is that we need to make sure providers who run out of money are actually spending the money for services that make a difference and it is not just, "bill, bill bill" but it is, in fact, "treat, treat, treat." We need to open the funding gates wider at the end of the year to make those budget adjustments when that happens. But it will happen, as we do that, with accountability because we already have one of the highest per beneficiary claim rates in California. In other words, we see more Medicaid kids than any other county in California both in percentage and in absolute numbers and the claims per recipient are also among the highest. So we need to say, "Well if all of that is true we should have the healthiest outcomes."

2. **Question:** In terms of the Health Neighborhoods, what is going to be the amount of funding per neighborhood?

   Response: Right now there is no dedicated new money or allocation for Health Neighborhoods; we are pulling together the resources as best we can. We are trying to combine Innovation with what the Department of Public Health is already doing around health outreach and what The California Endowment is doing with their community engagement project. If we are successful in some of these federal grants we will put that money into Health Neighborhoods. The big money in this will be the 90-10 care coordination that California is finally applying for. That will give us resources to pay 90% of the care coordination costs for chronic conditions, which included mental illness and substance abuse. Virtually all of our folks will qualify, though it does not pay for services it does pay for the care coordination. If we get those people that will be the work force, many of their peers that we will employ, Promotoras like, will be a part of the Health Neighborhoods.

3. **Question**: For the service areas that do not have a "Health Neighborhood" (service areas 3, 5, and 7) there was already the beginning of talk of organizing ourselves for a Health Neighborhood for our area. I am thinking about East Los Angeles, more specifically. Should we pause, the process and wait until a Health Neighborhood comes to our neighborhood? Should we join the closest one? What is your suggestion?

   Response: My suggestion is that you do not pause your organizing and also contact Kathleen Kerrigan. What we are going to try to do is harness the energy in places that want a Health Neighborhood. East Los Angeles is a perfect place and it is already on our expansion list. For Service Planning Area 7, the department is already doing several thought experiments. Pomona presents a particular opportunity and challenge because of the tri-city issues there. There is energy that is moving forward in the Hawthorne-Lennox area and Service Planning Area 5. We do not mean to push back any community engagement that others want to do and it is good if it gets coordinated through Kathleen Kerrigan's work so that we do not step on each others toes.

4. **Question:** Your model is going to be a system-based model of Health Neighborhood. What tool is the department going to be using to measure the outcomes as it relates to various aspects of what you intend to do and how you intend to achieve it? How are you going to fund that, which normally the county does not want to pay for? What are you going to do to measure whether or not what is being done is culturally competent or effective? Who is going to pay for that?

   Response: Academic partners possibly. Both of those questions that you asked are the questions that Community Partners in Care was meant to deal with. Dr. Wells, Loretta Jones, and the group that has been doing Communities Partners in Care are submitting various grants to look at that. One of the grants that they are submitting is an evaluation process for the combination of community engagement with government planning to produce community outcomes. Somebody forwarded to me an issue of a journal that was dedicated to what kind of community empowerment service models ought to be explored for the implementation of the Affordable Care Act. They basically were trying to estimate the percentage of improved health that came from various factors and how it came from Innovation and care, improvements since self care, the social environment, and the physical environment. Those last two, the social and physical environments, the community outreach component of the Health Neighborhood does. The first two, the self-care and the medical care can come from the consortium, the "little h" and "little n." What they are talking about is how those two components come together.

5. **Question:** As you develop more precise access standards where you are going to focus on how long it takes to get into the system and, I assume, hold people accountable to do that, in the absence of a major increase in resources, how will that impact the rest of the people in the system? In other words, will all of the resources then shift to getting people in and there will not be much left once they are there?

   Response: You highlight important dangers. There is another one that you did not speak to that I expected you to speak to. "Will we have a dual level of care that people with Medicaid will get a different access expectation than the people without Medicaid?" Our goal has been providing care by need, not by funding source. But this may push us into a different model. We will definitely be moving our systems into something like a managed care model where people receive what they need, but also have movement through the system rather than being stuck in the system. But that also means that we need to get engagement and partnership with the physical health community so that stable people can continue on their medications in the context of a primary care physician and with social support from their Health Neighborhood. What we need to do is to have some

	community engagement process. I have been accused of making everything that the Department of Mental Health does into a Health Neighborhood now, but if we do it right it really does touch every aspect of what we do. If we get somebody to get their medication from their primary care and they get social support and the kind of group social activities through their faith community or community group then there is space in our system for the new access. Your engagement in this process, advice in the development, and help in the implementation will be crucial to achieving these goals.
State Budget, Legislation, and Related Issues	*Susan Rajlal, Legislative Analyst*, County of Los Angeles, Department of Mental Health ** See handout for additional information "Quick List of Key Mental Health/Substance Use Disorder Issues in 2014/15 State Budget" 1. **Budget Increases and Emphasis**. Budget passed on June 15th. Summary handout from California Mental Health Director's Association is included in the meeting packets. With the realignment in 2011 it changed the way that we get our money. We get our MHSA funds from the state as they come in and out in the same month. But also we also get funding from the 1991 realignment and the 2011 realignment. Because the economy has improved we have growth in both areas this year so there is some growth in our funding. For the 1991 realignment a conservative estimate of that statewide is a $6.3 million increase. For the behavioral health sub account, which includes mental health and substance use a conservative estimate is $41.7 million statewide. Senator Steinberg was very dedicated in carrying our message that, many of the people that have mental health issues are actually in our criminal justice system. In order to help them successfully be diverted from that system it takes lots of resources. So you will see that the MIOCR program, a previously successful program, was reinstated and that will go to through community corrections. $100 million state general funds are allocated for supportive housing, it is very clear that there is an effort with the improvement in the economy to fund some of these things that are so necessary. 2. **Senate pro Tem Update**. This is Senator Steinberg's last year as the California Senate pro Tem and we have been looking for other members of the legislature to work with that are interested in mental health. It is important to note that the incoming Senate pro Tem is Kevin De Leon, representing Senate District 22 (includes Los Angeles, Alhambra, East Los Angeles, Florence-Graham, Maywood, San Marino, South Pasadena, Vernon and Walnut Park). That is great for us because he is interested in mental health and gives us an opportunity to meet locally with his office. If you are providing services in his area or you are a constituent living in his area it would be really important to have an appointment with his office locally and let him know what is important to us. He is interested but we have not worked as closely with him in the past as we would like to. So this is a real opportunity in the season between September 15th and January 1st to make those issues known to his office. I spoke to him recently and he said he was not very aware of any mental health providers in his area. If you are in his area we recommend you stake his staff on a tour of your facilities and community served. 3. **Parity Bill.** In August we are in the period where we are finishing up with the bills. The bills have to be out by August 31st. They have to be signed by September 13th by the Governor for them to pass. The enforcement of the parity bill that we have been working on unfortunately is turning into a 2 year bill. We will not see that come January 1st but we will have a chance to continue to work on it.

4. **Mental Health and Law Enforcement Partnerships/Coordination**. There is an increased interest in what is going on between law enforcement and mental health for people in the community that need mental health services. A joint hearing of two Senate subcommittees was held on this issue. One covered behavioral health and mental health and the other was on justice reinvestment. One was held in LA by Sebastian Ridley Thomas and Reggie Jones Sawyer with about 200 people in attendance. One panel discussed what we know works as a model for diversion or helping people avoid the criminal justice system. The second panel talked about what we have and what our challenges are, the panel included Dr. Robin Kay. The third panel was law enforcement and included California Highway Patrol as well as the head of the post, the officer's training academy, and the Los Angeles Police Department and Los Angeles Sheriff's department. From this hearing it was clear that we have things in Los Angeles that we know work and are working well together. A key issue was the need for more training for law enforcement. Currently there is an average of about six hours of training for most law enforcement officers across that group that is related to mental health and crisis intervention. The post academy has numerous modules related to mental health and intervention. The biggest thing would be to get funding for additional mental health and intervention training, at the end of the hearing it was kept open as an issue. There will be three additional hearings that will be held regionally throughout California. One big issue will be funding for more training for law enforcement throughout the system.

5. **Assembly Member Sebastian Ridley Thomas**. He is very interested in mental health and has indicated that, beginning in September, he is going to hold a series of town hall meetings related to mental health and behavioral health issues. Information on these town hall meetings will be shared with the SLT. These will be an excellent place for us to put forth ideas that are important to us related to all of these issues.

FEEDBACK

1. **Question:** Do those trainings include the community integration training with regards to relations between police and consumers including the Memphis model?
    a. **Response:** There was a lot of discussion about the Memphis model and how valuable it is and there is a need for that kind of training. So that was noted in the hearing.

    b. **Dr. Southard**: A lot of law enforcement institutions in Los Angeles use the Crisis Intervention Team or similar trainings such as the Memphis model. There is a coordinator for LA County to provide that information back to the state for exactly all of the different models of law enforcement training that we already have in place in so that when that goes forward they build on what is in place rather than try to ignore what we have got going and build something that is unneeded.

2. **Dr. Southard:** Some of the people in the room may be able to influence another important legislative item, Senate Bill 82, the Investment in Mental Health Wellness Act. This bill is crucial for the workings of a number of the initiatives that we have moving forward. It appears the California Health Facilities Financing Authority (CHFFA) component, which is the residential and urgent care center building component of it, may have run into a regulatory glitch. It is trying to use the same regulations that were used for the capitol funding for MHSA which states the county needs to own or be on the deed for the facilities and that will not work for the acquisition of either the urgent cares or the crisis residential

	programs. Apparently it is first the regulation, and more importantly, CHFFA council's interpretation of what that regulation means. DMH will seek legislative clarification on those regulations because the county is not going to own all of these crisis residential facilities throughout the county. In many cases they are only practical because an agency is using a facility that they already have and using the money from the grant to renovate it. Those are issues that need to be handled by the department. If any of you have leverage when that comes to pass please help us move that forward. 3. **Comment:** LAPD representative - The LAPD has a four-day mental health intervention training that is currently provided to their officers every other month. The next training is in September. The other thing is that the California peace officers standards and training (POST) put out a mental health update course. It is a 2 1/2 hour primer for officers in the field that provides crisis de-escalation and management for calls of service involving persons with mental illness who were in crisis, all sworn personnel in the LAPD are mandated to take that course. There is a lot of proactive education going on with law enforcement. I agree with Dr. Southard, we in LA County should be grateful because there are a lot of forward thinking individuals who are pushing for that type of training. We just need to build on that training and standardize it so that all of those officers interested in this topic receive additional training. Also, the Emergency Outreach Bureau, through DMH, has been providing training to a lot of the smaller agencies, not necessarily the four-day course, but those orientations are being held on an ongoing basis. For more information on trainings, check twitter. 4. **Question:** I have been in contact with multiple agencies such as Claremont, Pomona, La Verne, and West Covina and they are not getting any training on mental health, culture or religious competency. Can we, as a county, reach out and make an effort to involve them in training? a. **Response:** The difficulty I referred to earlier is that Pomona, La Verne, and Claremont have a different mental health entity. We can contact Tri-city and raise their awareness. The fourth place was West Covina who will be approached. b. **Response:** The answer from Tri-city themselves I know for a fact that they have been having difficulty arranging these things because the chief of police departments are not responding to them.
MHSA Innovation Planning	*Rigoberto Rodriguez, Facilitator* A. Let me provide an update on the agreements thus far for those of you that are just integrating yourselves right now and some updates on what the SLT Standing Committee has been discussing. Then we want to make the connection between what the department is doing with Health Neighborhoods and how that relates to what we are doing. We started in June, diligently meeting, and gathering ideas and really developing the framework for the Innovations plan. Our hope is that based on the conversations that we will have today and one or two meetings with the SLT Standing Committee we will be able to present to the SLT a proposal at our next meeting in September 17th at which point the 30 day public posting begins and it will then kick our proposal or plan to the Mental Health Services Oversight and Accountability Commission. These dates are really important because the sooner we finish the sooner the other parts of the approval process kick in. There are more steps than this because the plan then has to go to other points. Our intent is to make Innovation funds available as soon after July 1, 2015 as possible. It is a very ambitious timeline, similar to the one that Innovations 1 went

through. Hopefully if there are things that do not get resolved in these meetings you can always contact me, the SLT members or members of the SLT Standing Committee. If you have any questions do not hesitate to contact them. We make sure to foster as much communication so that we can complete this work within our timeframe.

B. **5 Planning Principles.** The *first* principle is that we intend to serve all age groups explicitly. You will notice that we are not only going to serve children, Transition Age Youth (TAY), adult and older adult age groups, but there is a 5th category - intergenerational. This is based on the recognition that for some communities the cross generational experience is crucial in terms of trauma, historical trauma, etc. The *second* principle is all proposals now belongs to the SLT and can be modified. The *third* principle is that the SLT, as you saw last time and this will continue, will have the liberty to keep combining ideas, putting them together, repackaging them and changing them as well, this creativity is really important for us to come up with the best ideas possible. The *fourth* principle is around conflict of interest. This principle is crucial but at this stage in the planning process we are all going to be responsible for regulating conflicts of interest. It is important for individuals to self identify their proposals when they are being discussed. That does not stop you from participating; we are striving to be transparent with the process. Finally, the fifth principle is that as we go through this work, there may be differences of opinion and disagreements but we are all responsible for reducing disparities together. This principle should be used as our compass. Those were the principles that the SLT approved so they will continue to be used.

C. **Health Neighborhood.** Last month the SLT adopted the Health Neighborhood framework to guide the development of the MHSA Innovation projects. The work that has happened subsequently is documented in the summary document that was email out to the group. The document represents what we have done for each of the age groups and Health Neighborhoods. There are examples of us beginning to implement this recommendation that the SLT adopted.

D. **Dispersed Populations and Non-Health Neighborhood Projects.** We are trying to make sure that if there are populations that are not living in any particular or concentrated area and are dispersed geographically we have a strategy to serve them. We are also going to work on developing a strategy and model for projects that do not fit into the Health Neighborhood framework. The Executive Management Team (EMT) and the SLT Standing Committee are recommending that the bulk of the resources, we have not determined how much or what percentage, will go to the Health Neighborhood and then we will figure out what proportion will go to those that do not fit in the Health Neighborhood framework.

E. **Health Neighborhood Review.** Health Neighborhood summary document shared via email. 5 ingredients of a Health Neighborhood. In terms of a Health Neighborhood approach it seeks to achieve population level results. What we want to do is see if we can achieve positive mental health for the whole population in that service

area. That is different than performance level results which measures those are enrolled in services. Results are the outcomes, conditions of well-being in different respects, health, mental health, etc. The specific condition of well-being that we want to achieve is positive mental health. Historically, in terms of social policy we have funded services of different kinds for people that meet certain eligibility criteria. What we have found in communities that have high concentrations of poverty and other disadvantages, whether they are living geographically concentrated or whether they are marginalized in other ways, is that investing in services has not generated better outcomes for a whole community. There are many programs that have worked really well for those that receive the services but not the community as a whole. MHSA, Community Services and Supports, and Full Service Partnerships have been showing good outcomes but when you add up all of these services they have not impacted the poor outcomes that certain communities are facing. This is why we are trying to, through Innovation, go one step beyond what we know we can do well, and see if we can also contribute to better mental health outcomes in our communities. Our focus is population level results. In order to do that we have to focus on not just treating the problem, because that is what we do over here with our services, what we try to do is try to go upstream. What are the factors that are contributing to the problem as it exists right now? In terms of homelessness it is not just being able to put together a good system of integration for those that are currently homeless but can we take some steps back and see, what are some of those contributing factors; not all of them, but what is one critical one that we might be able to tackle upstream? The same goes for folks working in the field of education that might feel like there might be something happening in education that is also contributing to, again, poor mental health.

F. **New Generation of Health Neighborhoods.** These place-based approaches rely heavily on a data-driven framework. Not only institutions collect data but communities can also collect data, be clear about what the long term results are, the short term results are, what indicators or measures you are going to use, what is your baseline, etc. It is very data informed so that we know if we are achieving results or not and if our strategies are working or not. These last 2 are really also crucial for this new generation of placed based work that we are using to frame Health Neighborhoods. They rely on a specific structure and process. By that I mean that the structure is one that uses a multi stakeholder group. It includes services and supports from mental health, physical health, substance abuse and other services and supports. But it also includes residents, community based organizations, faith based groups, etc., working together as a community partnership. That community partnership is the entity that leads a broadly supported change process to improve those population level results.

G. **Integrated Care Coordination.** Coordination of care includes DMH, the Department of Public Health, the Department of Health Services and other departments. As DMH is doing this they are also starting to reach out to the informal supports. The SLT's focus is to be able to collaborate with them but keep pushing for population level results.

H. **Community Capacity.** Finally, the last component of a key ingredient of a Health Neighborhood approach is that

it invests in community capacity. It invests in the ability of residents and community organizations and others that are dedicated to that community so that they can continue and sustain that work beyond the funding stream. Or through the funding stream new funding streams keep sustaining this effort. Sometimes we walk into communities, we offer a service, there is a 4-year timeline on Innovation plan, and then we are out of there. But what is left in the community? That is the 5th key ingredient. What you are going to hear about later on in your small groups is how your peers are trying to create and apply this framework to generate better mental health outcomes for specific populations by age and communities.

I. **Preliminary framing.** You already heard about going upstream so you are going to hear a little bit more about what some of those upstream factors are by age group. There was a complicated issue about how far upstream should we go. If you think about causes to a particular issue that we are looking at we could go really far upstream. There are folks who are thinking, "Should we rebuild our neighborhoods physically?" Some of those things, as the literature as shown on place based initiatives taking 10 years to achieve, and that might be something we should aim at, but there is also what we have seen with place based initiatives we also need to have intermediate outcomes. What can we do that can manifest itself as an outcome within 3 to 5 years in our communities that tell us that we are going in the right direction? However far upstream we go there is an intermediate outcome that this group has adopted, the SLT Standing Committee, and that is a focus on trauma. The group felt that trauma is so crucial and central to mental health outcomes that that would have a strong enough nexus to positive mental health. Also, something like trauma is a concept that can make mental health everybody's business across other areas.

J. **Age Groups Discussions.** Focus on what are those factors that are contributing strongly to trauma with your age group, and through that conversation, be able to develop what might be a core model or strategy for your Health Neighborhood that will help you intervene on those factors?

K. **Overall Question.** Innovation projects have to answer a question we don't have the answer to. Preliminary question: "To what extent can a Health Neighborhood focused on preventing, reducing, and intervening early, with trauma as our intermediate outcome, help to produce positive mental health for a population as a whole?" That is the question we are going to use to guide all of our work. We can modify it later if you would like but for the moment that will be the question.

FEEDBACK

1. **Question:** I am not sure if I really understand that intergenerational population.
    a. **Response:** For children, for example, you could have a Health Neighborhood that is focused on reducing trauma for children. You could have another one that focuses on reducing trauma for adults. So you build your outcome framework that focuses on adults, for example, or TAY. There are folks that really

	want to focus on children because every population has that large age span. So there may be some folks that are interested in children 0-5, others in the later years, etc. Just working within your particular age group may mean that you have to divide it into subsets. But the intergenerational one might be one where you are focusing on, for instance, cross age. For example, a family: grandparents, children, etc. We wanted you to have the liberty and space to think across age groups.
Age Group Discussion Updates	<u>Transition Age Youth (TAY)</u> A. We want to focus on the outreach, engagement, and education piece, utilizing strategies whether existing or innovative to really reach out and incorporate TAY into the Health Neighborhoods but as well as engage them in the planning process. One of the questions that we brought up was, "Where is the TAY in this planning process?" As we talk about innovation and really how to incorporate TAY into Health Neighborhoods where are the TAY in this whole strategy? So we really want to focus on the entire population but emphasize really trauma they may have experienced coming out systems, exiting probation, Department of Child and Family Services, transition between schools, high school to college to vocational school, and dealing with issues that include racism, cultural and ethnic issues, Lesbian/Gay/Transgender/Bi-Sexual issues, bullying and homelessness, as well as TAY as parents, a TAY in a dual or multiple roles within their own family, and to really utilize outreach and engagement workers who look like TAY, going away from the traditional behind the desk type of services and utilizing community resources, utilizing peers that are TAY age to reach out to TAY and to focus on preventing issues from becoming more severe. We looked at utilizing innovative factors. Social media and texting came at the forefront. TAY use their phones not to call someone or receive calls but to text someone or receive texts; utilizing Twitter and social media really as a community within itself to really reach out to TAY, to build healthy relationships because a lot of TAY are utilizing social media but there are predators and they are developing negative relationships that really are detrimental to the overall health of TAY. The underlining question that we had is, "How do we decrease social isolation and reconnect TAY in a sense of community and neighborhood, to really bring them together?" We can have these Health Neighborhoods. We can have services available. We can have community resources available, vocational, educational and housing. But if we do not outreach to the TAY and engage them in this process the services in the Health Neighborhoods will be for naught. B. Remember that what we are trying to focus on is trauma. Trauma among TAY, you identified some critical points where that happens around transitions. But one way to get at that might be that social isolation-- it might be that primary causal root that leads to vulnerability around trauma or trauma. So maybe that is something you may want to continue to explore because then you would then involve TAY through a planning process around identifying strategies to address the social isolation through a community based approach. That is one way to focus on creating healthy relationships as a response to social isolation.

ADULTS

A. Our last SLT Standing Committee session we did a lot of work in identifying root causes and so we identified things like poverty, violence, lack of education, cultural media--the cycle, kind of, of culture. We used that as a jumping off point to talk a little bit more about strategies and specific populations we wanted to address. We talked a lot about folks who are incarcerated. So either going into the jail, making connections for people going out of jail, and housing, and really the focus of the conversation that we brought from our last meeting is creating community around people; so not just wraparound services but wraparound communities so [inaudible] create for effective outcomes to improve life quality. Ideas that came about, what we really tried to work on, was coming out of jail, having housing and employment ready for you right away, not necessarily mental health is the catch, but can we then start to use peers and other things to create community around the person who is unconnected or socially isolated.

B. So we have got maybe 3 projects in mind. One is looking at focusing on folks who are coming out of jails. One is focusing on folks who are going into jail, jail diversion. One is all about community mentoring and community connections. We have a proposal on the table, the Boys and Men in Color, Veterans population, other Under-Represented Ethnic Populations and how do you make a community more welcoming and engaging? How do you create better and stronger communities? We talked a little bit about using the already identified Health Neighborhoods as maybe a springboard for our purpose.

FEEDBACK

1. **Question:** In terms of trauma how do you see trauma in that conversation so far?
    a. **Response:** We also talked about with everything that we develop that there would be a trauma informed piece to it. Even in the community's grassroots settings where they may not think of themselves as individuals that treat trauma we can educate and help them with engagement which is a big piece with this population.

    b. **Response:** We identified poverty and violence as part of this. So I think strategies that will disrupt that cycle.

OLDER ADULT

A. We began by taking a stab at the definition of trauma. Trauma can be defined broadly as any historical, actual, perceived, or potential experience that results in unwanted or negative physical, emotional, social, or psychological harm that impacts the context in which the individual views themselves or others in their community or social environment. We thought it was important to begin with a definition of trauma because

that informs the context of our discussion in terms of what will fit under that umbrella.

B. We looked at some of the root causes of trauma as it relates to older adults as losses, declines in health, loss of independence, death of a spouse or partner and food insecurity. We also looked at inadequate financial resources, also exposure to war, genocide, etc., loss of role and meaning, social isolation, physical, emotional, and/or financial abuse, violence in a particular community, domestic violence, diminishing support systems and unresolved trauma from either child or adulthood. Those were some of the root causes that we discussed briefly.

C. We are looking at this in terms of what we could do in working with a community of older adults. For example, a housing unit or complex that serves older adults, embedding services within that particular setting such as wellness type services around empowering those older adults in that particular community, impacting the safety aspects of the neighborhood, reducing the social isolation, and improving the safety. We also looked at environmental factors within neighborhoods that make it tough for older adults.

D. So we are looking to bring together systems as was talked about here: health, mental health, substance abuse, department of aging; systems together to improve wellness service to older adults in a particular underserved community. When we say underserved we are referring to a certain percentage below the poverty level, high crime rate, cultural diversity and sensitivity and those sorts of issues.

E. Our second idea involves an outreach and engagement component to the Lesbian/Gay/Transgender/Bi-Sexual older adult community. Our third idea involves a specific Health Neighborhood type concept specializing in older adults where we bring together older adult specific agencies, partners, and collaborative in a local community where older adults can access a myriad of services freely. Those are some of the broad ideas that we discussed today.

<u>INTERGENERATIONAL</u>

A. We believe a paradigm shift needs to take place. So far the system has divided our families and put them into different age group boxes because of funding [inaudible], different reasons and so forth. Definitely it is time to make a change. If we are going to make the most culturally competent, holistic, and inclusive Health Neighborhood we need to see and treat the family as a whole.

B. The root causes of this group are the divisions and separation of the different family members; being boxed in and separated into different age groups, being treated and seen as a whole, different stressors due to role reversals, role confusion, displacement of family roles, economic and historical trauma, cross generational trauma, and the different levels and speeds of acculturation. Our communities are coming in from different

places and are in different times in their lives and different times in their acculturation levels.

C. To address all of these issues and many more we believe that having the possibility of having a family wellness drop in center; maybe have a pilot where we have a mini neighborhood in this family wellness drop in center where it would be a very supportive environment where the whole family would be served and be very inclusive and holistic. We talked about making sure that we use the family parameters, for example, as well.

D. One of the things in terms of what specific questions this would answer we would try to find out, "What is preventing us from working with the family as a whole?" As we know there are different funding sources, different billing issues and so forth that prevent us from doing that. How do we work with the family as a unit? how do we collaborate with partners and collaborate and partner with different age group services, different age group agencies to work with the family as a whole? How do we collaborate and partner with already existing natural community support systems and organizations to increase community support and social connection?

E. We definitely talked about going beyond the 4 walls, going beyond the legal entities and really work with the community organizations, maybe bring back the incubation academy and have some technical assistance. I think the department may be working on this already to bring in more community agencies to be part of the master agreement list so that they can be part of this idea that we are proposing; and of course making sure that everything that we do, "How do we treat the family as a unit in a culturally competent, sensitive, and appropriate and relevant ways?"

<u>CHILDREN</u>

A. We started first with the summary from the prior work group to check in with everybody to see if what we covered was there and that it resonated with folks. So we looked at all the types of stressors contributing to trauma; episodic, chronic, toxic, stress, and got more input from members who joined us today and talked about the critical aspects of actually looking at very young children and screening identification as well within these models that we talked about. We looked at about 6 or so different models in our prior discussion on how to do broad based community intervention to respond to these different types of trauma.

B. But then when we came down to the hard discussion of these specific questions we could not contained ourselves and how a hard time going all the way upstream to the general population. We started with the world we live in and that is kids in child welfare and foster care. We talked about a situation about a young man kind of landing in a medical facility in an emergency situation and brought their by police in total isolation from her foster parents. We used that as an example of, "Where did that break down?" Another child in wraparound with trichotillomania hair pulling; super anxious child acting out in a lot of contexts, being told by the provider to sit on their hands. That was the intervention.

C. But all of those things start to move backwards. Where are the foot points of intervention or support for these kinds of situations? So we began the discussion with where are the points where systems re-traumatize. Where are we missing key support folks to have a broader based community support? What it all seemed to come back to was the need for a much more broad based community awareness at the neighborhood level, at school levels and even child welfare

system. We picked any kind of setting with any type of population. What type of trauma are we actually speaking to?

D. One of the key things that out of the discussion with schools was that we have wellness centers that have already emerged in the Los Angeles Unified School District and integrated school health centers as well. Those become key places of not only to extend services and be places accessible to a larger community but where some of this community education can start to occur to, in a sense, make trauma everybody's business. We can say mental health is everybody's business but is mental illness or trauma everybody's business?

E. We keep coming back to this notion that the stigma and the systems that guard against privacy, the relative isolation of folks with lived experience and have such trauma needs continues to abnegate or lead the community to pull back or owning responsibility for supporting these families. Our system does not fund folks to do community education to break that down significantly. Instead we have service navigators who help you get into service but do not do hard community education and awareness. We have programs now, mental health first aid, emotional CPR, and are starting to break out into that world of larger community education, not just psycho education but formal training in community awareness.

F. But we need that level of proactive folks from the community at the neighborhood action council level, at schools, wellness centers and the child welfare system who are really engaged in that effort. The key question is, "What difference will those individuals make doing that education to ultimately reduce trauma, traumatization within our system or re-traumatization other than just provide care pathways or access to service. What is the literal impact on a community putting its arms around those in need as opposed to isolating them and saying it is our job? Our job is ultimately to put ourselves out of business. Instead what we have done is put ourselves in having to deal with overwhelming business that we cannot handle because we have not paid attention to who can really support us in that effort upstream.

FEEDBACK

1. **Comment**: In that last question you were posing another one crystallized in my mind. You mentioned a problem that poses a question and that is, "Can a Health Neighborhood help a broad community take ownership over mental health?" Then there are sub questions around trauma. But it sounds like there is an issue there of communities pushing away—
    a. **Response:** Community and institutions. We talk about schools sometimes pushing back saying, "Really we cannot afford the time for our students. It competes with educational goals. We do not want that level of service." We are working on both ends where stigma and push back occur institutionally and at a community level.

2. **Comment:** With your traditional mental health approaches where we fund services and programs we are not able to get at that level or layer.

3. **Question:** I think that with children and TAY one of the things that I heard was the beginning of a logic model.

You both posed that by focusing on specific social determinants of health you impact positively the health of the communities that you are working with. I think that is where we need to go. I am going to encourage each group to think about what social determinants do you need to then make a difference in overall population health. What does that logic model look like? What impacts what and what does it result in? How do you measure that?

4. Question: With children I heard the upstream sort of approaches about outreach and engagement. You have to drill down concretely. What would that Health Neighborhood look like? With TAY I think it was decreasing social isolation and the social media strategies and other things that would do that.

5. Question: The other thing I wanted to mention is that the next thing that we will have to do is make sure that these projects are innovative. If they have been done before, particularly another county, we have to be able to say that the reason why this is innovative, this is how it differs from Fresno county or something like. This is particularly true with the intergenerational. What I heard Leticia talk about are family resource centers. Many counties have implemented them in Prevention and Early Intervention. If we were to implement family resource centers here how would they be different from what is in our 3 year plan? How would we implement them differently in Los Angeles County? What is the learning there?

6. Comment: The next steps need to go back to, "what are we trying to learn?" The learning then will inform the rest of the system. Those are the sorts of questions that we need to ask and be prepared for before we go to the Oversight and Accountability Commission to approve this.

7. Comment: Basically I am really impressed with all of the groups. I see an underlying theme which is engagement. How do we engagement them in a different way--community up--and get the pieces of the community talking to each other and how do we use peers to communicate with the people? Like with TAY, how do you have TAY talk with TAY and social media? That is a very innovative idea. We just continue to talk about, “How do we engage on the level of the people that we are engaging. How do we engage the community to help us engage and with training? It seems those are themes.

8. Comment: About the intergenerational issues, I think each of the groups focused on trauma related to the age group they were looking at. We heard a little bit about intergenerational trauma. That is different from children's trauma, etc. Most of what the discussion from the intergenerational group I think should be carried over into all of the age groups. It is really about the solution to trauma. We are going to deal with intergenerational issues dealing with children and older adults. I do not want to take away that there is something called intergenerational trauma. Most of the discussion has to be carried over, just like cultural competency, into all of the different age groups.

	9. **Comment:** What I heard as a consistent theme was outreach and engagement but what I felt was missing was a social marketing component which is all about engaging the community whether it deals with TAY, outreaching to them through social networking, or through the parents, or older adults through brochures, if the objective is to eliminate and address trauma then we have to speak that language to the community. That is when we begin the engagement process to get them to become more willing and accepting to this new way. Mariko hit the hammer on the nail when she talked about a paradigm shift. Essentially that is what we are doing: shifting the attitude and belief of how the community benefits and perceives what would be formerly mental health services into benefiting from an integrated system of care. 10. **Comment:** I want to make sure that I understood Jim. In a way I think you have it backwards. I just want to make sure that is clarified. I think one of the things that our group discussed and was excited about is that all of the age groups belong in the intergenerational. You cannot change a neighborhood unless you change the whole structure. That s what we are excited about. We just used the family wellness drop in centers as a possible model. But we wanted to discuss more fully other models that would test because we strongly believe that one of the social determinants is decreasing family defragmentation. By doing that you have a strong family you have a strong neighborhood. It all starts with the family however it is defined. That I think is what is motivating us and we have not clearly done a logic model. That is really what is exciting. The fragmentation of services already shows us that that in a sense causes the family to weaken. 11. **Question:** Can a Health Neighborhood approach that strengthens the family reduce trauma? It sounds like the way you have landed on intergenerational is within the context of the family. The family is the holder of different generations. If you can focus on something that strengthens the family you are intervening on the intergenerational thing that we are talking about. The other connection that you are making is that if you have a strong family you have a strong neighborhood. So there are several things that lend themselves to questions because we do not know but we can begin to test that. 12. **Comment:** I really like this intergenerational group because I really think that trauma does not really stay in one generation only. It goes from one generation to another. If the mother is traumatized then it is passed to the child. So I think that the intergenerational concept of trauma appeals to me. I think that is what I am hearing from everybody here. 13. **Comment:** As we make the transition from MHSA funding as we have known it to this innovation piece, rather than marginalize it as its own unique thing and we are going to see if it is cutting edge and what are we going to learn anyway I think we have got to do something more radical and that is break out we have created an entire Department of Mental Health around 4 program bureaus, older adults, adults, TAY, and children and yet we have just come to the conclusion of lifespan critical nature. We continue to break in our age groups to do this work. This is telling us something. I think our system is really going to have to work through this very

	discussion and how it is going to impact even the bigger Department of Mental Health structure because that is bound us with Evidence Based Practices as the other myopic version of the world when community defined evidence is equally compelling in the work that we are doing. 14. **Comment:** My thoughts on Intergenerational are the combination on what is building that family. Is it dysfunctional love or is it a positive nature core? If it is dysfunctional I have seen the dysfunctional love create bonds that are almost impossible to penetrate. You are going to have to look at that family unit. Who is the one brining hope to the family? Or that could be from the other iris of the generation. You have got to look for the hope. If there is no hope in the family, that is your starting point. If you have individuals coming together on a dysfunctional love you already have a model showing that they will come together for something greater than the dysfunction. A dysfunctional family can be one of the pillars of the family because they have already proven that they are already successful in a negative pattern. By introducing a new modality so this family can say they can now show and build together you have got to continually point that out. What is better than worse? Have them define what they can do better as a unit. That is building a new legacy and new standards.