COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, October 15, 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 on key issues from the County of Los Angeles – Department of Mental Health.
2. Present an update on the development of the MHSA INN Projects and provide input.
3. Endorse the conceptual framework for the INN Projects in order to refine the proposals further.
4. Agree on next steps.

MEETING NOTES

Department of Mental Health - Update	**Dr. Marvin J. Southard, Director, Department of Mental Health, Los Angeles County, provided the following updates:** A. There has been concern about how the Affordable Care Act (ACA) and the 1115 waiver will affect the behavioral health system in California. I think the news is good. 1. At this time the State Department of Healthcare Services has no stated intention of ending the mental health carve out. Right now, we are compensated for services on a fee-for-service basis. 2. There is also a movement to carve in the mental health service as part of a health payment, so we would be reimbursed on a per-member, per-month basis as a part of an overall health system. I believe something like this will happen eventually, but I do not think our system in California is ripe for that yet because the health system is not ready to receive the knowledge and skills we have gathered over the last decade or so, focusing on customer input and recovery processes. There will come a time when that happens and we need to prepare for that time, but the good news is that it is not immediate. 3. Even better news is that California has come to an agreement with the Centers for Medicare and Medicaid Services (CMS) for the State Plan Amendment and the waiver that would be necessary for implementing the drug Medicaid program benefit in California in a reasonable way. a. An important portion of that is that the federal government has agreed to waive the Institutions for Mental Disease (IMD) exclusion for residential drug treatment programs. What that means is that in the past if you had a facility of over 16 beds you could not bill Medicaid because it would be considered an IMD and therefore not eligible for federal reimbursement. They have agreed to waive that process for drug residential programs so they can be larger, which makes it practical to implement the residential drug treatment benefit in California. That is great news because as that

benefit rolls forward it will help us provide the services that are necessary, particularly for people that are homeless and have co-occurring disorders.

4. The waiver program on the drug Medicaid side is voluntary for counties. Counties need to opt in or out. The State is counting on eight counties to be participants in this early opt-in period as the first ones and Los Angeles is one of those eight counties that are being looked at for that. Ultimately, it is up to the Department of Public Health (DPH) and the Los Angeles County Board of Supervisors whether it actually happens here. I thought this was very good news and very good help to our system if the drug Medicaid benefit becomes available.

5. The County Mental Health Directors are trying to advance behavioral health components as a part of the 1115 waiver.
    a. One component is the waiver of the IMD exclusion on the mental health side, not on the substance abuse side, for freestanding psychiatric hospitals. The IMD exclusion was meant to prevent the warehousing of mental health clients in a quasi-state hospital and have the federal government pay for it. So, what has been a long-time exclusion was furthered by the Olmsted Act which prohibited states from taking actions that would tend to warehouse clients for a long period of time, which has led to the downsizing of state hospitals and some other things like that.

    b. We would propose lifting the IMD exclusion for acute stays in freestanding psychiatric hospitals to show our good faith, in that we would be willing to consider limits. Maybe we would have the IMD exclusion for freestanding psychiatric hospitals limited to a length-of-stay less than seven days. To prevent serial admissions, we would say 'no more than four times a year.' Ultimately, we want to make it really clear we are trying to increase the resources for acute psychiatric care (because right now resources for adults are very limited) and to stimulate the growth of more inpatient beds. On the other hand, we do not want to increase anything that has to do with warehousing and long-term stays of individuals.

    c. We have been told that there may be some opportunity for us to advance the waiver. Apparently, the State of Washington has some experience in that regard and we are going to try to follow in that direction.

B. Our diversion efforts are proceeding with Jackie Lacey, who many of you saw was honored at the National Alliance on Mental Illness (NAMI) walk last Saturday. The next step is that the joint community report—that is being developed between DMH, the District Attorney and the GAIN Center—will be presented to the Board of Supervisors on Wednesday, November 12, 2014.
    1. The Board of Supervisors has already allocated a down payment of $20 million of Los Angeles County

General Funds to help that program. As you all know, we are already investing a significant amount of Mental Health Services Act (MHSA) funding in a variety of different ways to afford the efforts to create diversion opportunities where that is possible.

2. The game changer for this whole diversion project will be the residential drug treatment that will provide 90 days of supported treatment for individuals, many of whom will be transitioning from being homeless to having an ability to connect with recovery. We are very hopeful that these resources, as they become available, will also help with the diversion project.

C. Through the efforts of Mary Marx and Robin Kay, we were able to overcome a road block with regards to implementing Senate Bill 82, which focuses on crisis residential and urgent care centers. We were able to get the California Health Facilities Financing Authority (CHFFA) to agree to a work-around for this road block. It is inconvenient for us but actually helps us obtain the available resources. We are expecting a Board letter that would start the funding process for the CHFFA projects to come to the Board of Supervisors on November 12, 2014.

D. The Katie A. State Settlement is in its final stages and there are a lot of disagreements. The disagreements really have to do with the costs for other counties. They are saying there is no way they can implement the kind of programs we have in Los Angeles because they do not have the resources we have in Los Angeles. We are basically telling them, "Yes it is hard, but it is worth it." We will see what happens.

E. We are making strong advances in our ability to implement our health neighborhoods. We have a community meeting we are planning for December 10, 2014. We are having a community meeting at The California Endowment that will focus on the health neighborhoods. It will be highlighting the accomplishments we have put in place thus far and getting community input on the next steps to be taken for the implementation of our health neighborhoods.

The following dialogue ensued after the update:

A. **Question**: I have a question about how the State is dealing with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and Medi-Cal Managed Care programs. You mentioned that mild and moderate folks with EPSDT who have been traditionally served by the Department will be shifted to the managed Medi-Cal programs or will they stay with the County programs as they have been. My understanding is that they will stay with the County. Is that right?
    1. **Response:** There is a major policy crisis on that particular issue overall.
        a. There are those, **not us** (LA County), that believe that the line between mild to moderate (and especially mental health) ought to be drawn in a such a way as to be as restrictive as possible with regards to accessing specialty mental health, to include as little as possible, and to have everything that you can make the health plans responsible for be the responsibility of the health plans. There are

some counties, mostly in northern California, that hold this belief with regards to EPSDT.

b. There are others, particularly in Los Angeles County, that believe that the boundary between specialty and non-specialty should be drawn as expansively as possible to have specialty include everything that it always has and more. Ultimately, our view is that we should include as much as we can in specialty mental health and have the public system—including our community agency partners—also contract with the health plans to do the mild and moderate.

c. From a customer perspective, "How are you supposed to know how ill you are to know to go to the right place?" If it is somebody's job to make it somebody else's responsibility to pay there may be a ping pong game with the patient as the ball being batted back and forth between who is responsible for doing what? From a patient care perspective it seems to us that we ought to have a system as inclusive as possible so people can get what they need wherever they go.

d. That is even more important if you think about what the State did with substance abuse. On the substance abuse side, they carved everything into specialty care except for alcohol. That is the only thing the health plans are responsible for. So, if we are trying to create a co-occurring system, patients will go to a whole different system for their alcohol and drug treatment, as opposed to their mental health treatment. So, to me, this design is just not workable from a patient perspective. We are trying to present to the State a model that is as inclusive as possible.

e. Dr. Shaner and Dr. Kay have been leading a work group including many of you here to divide levels of care that would do both things: provide a model of care that is inclusive as possible and yet contain costs so that the treatment is associated with outcomes. We do not want to pay $2 million for care for somebody and it does them no good. What we want to do is to have some linkage drawn between what we spend money on and the benefits that clients receive.

f. In early November I will be going to California Mental Health Directors strategic planning retreat and presenting what we are modestly calling the LA Plan about how to do this. We think the other plans that frankly, in our view, give the store away to the managed care companies would be disastrous to clients.

B. **Question:** In terms of bringing it down to the actual providers for substance abuse and, hopefully down the road, training for co-occurring disorders, Is there going to be an effort to bringing on board places like 'Cry Help' that really do not have psychiatrists on board and do not really treat co-occurring disorders? With my son, if I said he was under Full Service Partnership (FSP) when he was at Cry Help a long time ago, would it not be a good idea to call his case manager so you all could be on the same page to help him? They did not do that kind of thing. If we are going

	to get help for co-occurring disorders and there is going to be this advantage through the new program, how is it going to come down to Earth? 1. **Response:** What I would hope to imagine is that all of our mental health providers also get drug Medicaid contracts, all of our Directly Operated Clinics, all of our Transition Age Youth (TAY) clinics--every resource within the mental health system develops a drug Medicaid contract so that when people go in the door they can get what they need whether it is pure substance abuse, pure mental health, and anything in between that spectrum. I think we should develop a system that makes it easier to know where to go obtain the help you need that aids recovery. C. **Comment:** One of the things that they have been doing in Massachusetts and other places is the Recovery Learning Communities. I think you might want to take a look into what they are doing. It is very similar to the health neighborhood process, and I understand you have been pushing that. I think possibly that is something that DMH might look into and try to incorporate that here. 1. **Response:** We have been doing so much in a whole bunch of different ways with our health neighborhoods. We have been approaching it through the health consortiums, doing the community organizing, doing things with faith communities and I think we are at a moment where we are trying to take a breath and develop some models that are more concrete and specific to particular communities. As we do that we are going to also try to take a look at models from other places and see where we might learn.
MHSA INN Projects - Update	**Debbie Innes-Gomberg, Ph.D., MHSA Implementation Unit, Department of Mental Health, County of Los Angeles, provided the following updates:** A. Some of you signed up for the System Leadership Team/MHSA Orientation for this afternoon at 1:30 PM at 695 S. Vermont in the 10th floor conference room. B. Next month, we are going to present results from the 'MHSA Innovation 1 Projects' that focused on the integration of health, mental health, and substance use services. There are some pretty compelling outcomes so far, which will be finalized by the end of December. But we want to show you the impact these programs have had to date, for three of the four models. (The fourth model one has one more year to go.) We want to recommend that if the Department has available funding to fund these projects on an ongoing basis. C. In your packet there is a document that says 'MHSA Innovation 2 Projects: Health Neighborhoods.' This document is the beginning of the proposals that you will see next month, will be publicly posted, and then go to the Mental Health Services Oversight and Accountability Commission (OAC) for approval. It is a beginning document. I want to review the structure of the proposal. The beginning part of this document describes what a health neighborhood is, followed by the qualifications for and the primary purpose of the MHSA Innovation projects. The OAC has told us to select one and not more than one. A primary purpose will be checked off once proposal is completed and we know

	exactly what we intend to fund so that the evaluation corresponds with the primary purpose. D. Then there is a section on the challenge to be addressed by the MHSA Innovation projects and the stakeholder involvement. The next part contains the work of each of the Age Groups (including the Intergenerational Age Group), which starts on page four and goes throughout the rest of the document. Each group was asked to list their health neighborhood strategies, the key learning questions, and the proposed approach to disseminating successful outcomes. In other words, if the strategy is successful: What are the intended outcomes of the projects? How would you intend to disseminate that information? What would you do with it after the end of that project? Would you continue to fund it? Would you incorporate it into your already existing programs? What would you do? How will the project reduce ethnic and cultural disparities? E. In the next couple of weeks, the strategies will be completed and be definitive enough for you to review for November's SLT meeting. We will then publicly post the document and send it to the OAC. I am hoping that the OAC will hear this in January, 2015. F. A critical task for this morning and in the next couple of weeks is to be very clear about the specific strategies. For example, the Children's Group proposal presents the following strategies: 'To increase family protective factors, such as caregiver resilience, social connections, knowledge of parenting and child development, concrete support in times of need and children's social and emotional competency. Examples of programs, resources and strategies that have incorporated this goal are partnerships for families, strength-based and trauma-informed parent education groups, etc.' So what we need from the Children's Group to prioritize which of strategies you want to go forward with and then explain what these strategies are in more detail. That way, it is really clear what the strategy is, how it will be evaluated and how it fits into the rubric of the health neighborhood.
Key Concepts for INN Projects	**After the each group lead presented, the SLT members posed questions and offered comments. The following are the key points made during this section.** **A. Inter-generational Group** 1. **Comment:** Regarding the definition of the word 'family,' it is something we are still working on. We go back and forth between 'unit' or 'family' but it is definitely pending work. 2. **Comment:** When we started this work, we thought, "What is the definition of family?" And we thought that for TAY-LGBT runaway kids that are moving into an apartment, that is their family. There are very unique types of families, such as TAY living together. Or maybe there is perhaps intergenerational trauma across four generations all living in the same apartment. Or a Salvadoran family where the family is 14 people living in different part of Los Angeles, but it is family to them.

3. **Comment:** One of the indicators that we need to have on that board is #6. How does this link up with what the Department is already doing under health neighborhoods under the 'systemic' system (versus 'community' system)? The systemic system is supposed to have an educational component and other formal services. We need to make sure that what we are doing here with the health neighborhood has that link back to the 'systemic' system, so that it can be sustained.

4. **Comment:** In first reading this proposal, I was thinking that there is an assumption that the trauma is coming from outside the family, or external factors to the family or 'population-level' factors. But then there is also domestic violence as a major source of trauma, or factors internal to the family. I think families experiencing domestic violence are underserved. So I would ask that instead of defining trauma as something that only happens from outside the family to come up with some language that acknowledges domestic violence as a sources of trauma.

5. **Comment:** I am interested in knowing how the linkage will be between the different agencies and people trying to achieve the intended outcomes. In what pragmatic ways are they going to link up to keep each other informed and to build on their strategies?
    a. **Response:** That is the more detailed level and information that we will work on.

6. **Comment:** Will this reach up into the Antelope Valley and Palmdale? They are screaming about the need for services.
    a. **Response:** We do not have the regions just yet but your point is well taken. We need to come back and develop criteria around making sure that all the Service Areas are served.

7. **Comment:** Project Return implemented a program about three months ago around trauma-informed peer support. It was an eight-hour training. You might want to give Alice a call and get the name of the trainer.

B. Children Group

1. **Comment**: My initial thought was, "Okay, we are using these Evidence Based Practices to do this stuff, but this is supposed to be innovation: we are supposed to be doing something that has not already been shown to work." But then I thought that the innovation here is how we are putting all the practices and strategies together. However, that is not coming across in the proposals currently. Moreover, we already know the answers to some of the learning questions. If I were on the OAC, I would see this as already done rather than an innovation. I think there needs to be a better 'bringing together' of all the little pieces and showing the synergy that will lead to the bigger impact.
    a. **Response:** We want to go from 'systems integration' to 'systems innovation.' And the 'innovation' refers to the unique integration of strategies we already know have been working to some degree but are uniquely brought together in a selected place. That is the challenge: to bring these different

partners who have been working together in some cases together and in other cases in parallel but not all together along the same prevention continuum.

2. **Comment:** Another way to think about the innovation might be to take the concepts that Sam Chan talked about and apply them to specific places, such as a poorly performing school or a Head Start program, and see how this bigger neighborhood concept can actually impact the trauma issues within a small environment. I think that is a more manageable and do-able kind of project.
    a. **Response:** Learning question #3 alludes to that. "Can a specific community setting serve as a base for healthy neighborhoods?" It kind of gets at your question. That would be perhaps be one way of anchoring the three strategies--a specific location that may have this ripple effect or impact in a broader community.

    b. **Response:** It certainly could be in a pre-established health neighborhood that is already going on but we have not looked down that deep at the institutional level, in other words, at the impact of these principles on a specific place.

3. **Comment:** As I sit here, I can follow what you are trying to do as far as the strategies and I can understand that. But the content of each strategy—and even deciding, "Do I select an agency site? Or do I look at the individual?"—to me it depends on how you are going to ultimately define trauma to then be able to really determine the best strategy and program to be able to have a population-level impact on trauma. I do not know if you are going to have an opportunity later on to define trauma. It seems that you are trying to move beyond defining trauma and come up with a "system" when you do not have the definition of what that is actually going to look like across the age groups.
    a. **Response:** The definition of trauma is going to affect all of the proposals. We developed a working definition of trauma. That is actually one of the learnings: there are quite a number of definitions of trauma. We will circle back to define trauma broadly but we have also asked each workgroup to propose a definition of trauma for each age group.

4. **Question:** So will the group have a second chance to review some of these proposals?
    a. **Response:** Yes, our November meeting is when we are expecting some of the technical work done and also a next draft of the proposals.

5. **Comment:** I am hearing really loudly the one sentence that Sam said about, "How are we going to build the infrastructure around our learning questions?" When I coupled that with what Dr. Southard said about 'narrow the focus' so we can operationalize and accomplish more, somehow my intuition is telling me each one of these age groups and the overarching intergenerational group are the cornerstones of something we are building for the future. It is difficult because we do not have the answers. But if we focus these questions

around the idea of an 'infrastructure' and the question on trauma, what kept going through my mind was when Richard Van Horn defined trauma as the 'absence or interruption of a beneficent reality.' I did not have anything else to work with so I kept bringing that back to keep me focused.

6. **Question:** When we say "community" or "health neighborhoods" are we planning to try to use every entity that is in that particular geographic area to link them all together to do what we are planning to do?
    a. **Response:** Whether or not you link all of the agencies, and whether that is possible or not, the intention is not simply to link the organizations and networks in a community but to link them in a way that impacts the result we want to achieve, which is the reduction of trauma. Sometimes we approach with work with the idea of including everybody, but sometimes not everybody wants to play, either. Also, in terms of strengthening communities under this proposal, there is a relationship-based kind of approach of building or creating relationships that can assist with the reduction of childhood trauma.

C. TAY

1. **Question:** I really caught on to the concept that you are talking about with TAY being focused on social media, the leading edge of technology, and all of that stuff. But DMH is precluded from using any of that stuff. So how is your proposal going to deal with that particular hurdle?
    a. **Response:** We are looking at utilizing innovative social media and technology at the community level where departments and systems may not be so involved, so that in the beginning connections can be made within the neighborhood among TAY and community organizations that may not have similar barriers that the department may have.

2. **Comment**: I thought it was also important that a part of that social media outreach and engagement is the education about social isolation and trauma, what it is and what it is not, and using the TAY focus group to help us inform the education of TAY about these issues. This can lead to positive outcomes because once you are informed and have knowledge you have an idea of which way to go and how to get assistance and support if you need it. I did not hear that but I am hoping that is what we said.

3. **Comment:** I really like the idea that TAY who are socially isolated really want to be socially included. I just like the idea.

4. **Comment:** I really love the TAY-led events. We did work with the Black Women's Health Project a long time ago where they were trying to get support for TAY professional women. There was a point where they dropped out and they were trying to get them to come together. They were able to get them to come together around a project where, before they met on what they needed to do, in the project everybody checked in so they were providing support for each other as well as doing the project. I wanted to throw that out as a suggestion as one of the interventions.

5. **Comment:** I was looking at the cultural piece. One that you did not mention that is so important for TAY—since they are in the identity development phase—is the LGBTQ culture of young people trying to find their identity. Maybe you could add that to the cultural piece.
    a. **Response:** That was already included.

6. **Comment:** Yes, we have some challenges with communication and social media. That is where the innovation and the creativity come in. In my mind, we are facing the same challenges with intergenerational group when we have age groups and legislation that specifically uses wording around the age categories. But there is a 'communication' grapevine out there that is the way information is transferred. Part of our innovation is to find a way to communicate through that grapevine. So we have to be creative about communication, which is what the innovation is all about. If we do not put good information out there, then people are going to be making decisions based on bad information. That is something we have to look at the neighborhood level.

7. **Comment:** As far as social connections are concerned, why don't we have a type of a workshop or summit with the youth and let them come to the table either here or out in the neighborhoods where they feel comfortable? This can have a direct impact on them, get the dialogue going and let them give feedback to us versus us here all adults. It would be better having young adults giving us feedback.

D. **Adults**

1. **Question:** Does the proposal seek to add the employment menu to the Coordinated Entry System (CES)?
    a. **Response:** It is to use infrastructures that are being built through CES to do a matching with employment. We do not want to create a different system. Since that system exists already, why do not build this into this system? It can improve flow. If people do not need subsidized housing, then they can move out and we can get new people in because those people are working. It all fits together.

2. **Question:** Speaking about those that are coming out of shelters and being housed, being that some have dealt with trauma in the shelters and being homeless, once they are housed is there any type of system set up for them to work with? Sometimes in getting housing they can deal with another trauma. To keep them from being traumatized again and keep them on track as far as paying rent, is there any type of system that is been talked about to follow up with them on that?
    a. **Response:** We talked about a couple of things. One, recognize that people who are homeless have experienced trauma and just being homeless itself can cause trauma. So one thought is that when people move into a home that in itself helps reduce some trauma because they are not on the streets anymore. They are not in a shelter. Two, I think addressing the fact that people can get jobs and feel a sense of community that can also help them feel less traumatized. If you have thoughts about that

and how it can be incorporated into the model, we would love to hear your ideas.

3. **Comment:** I think that is important. For myself, seeing some people stay in shelters, when they come out and get housing…and then they are traumatized because they do not know how to deal with being alone. I think there needs to be a system set up for that, for being alone. Many of them form a community of support when they are homeless, and then when they get an apartment they find themselves being along, disconnected from a network of support.
    a. **Response:** We have noticed that in our programs. When we housed individuals that had been chronically homeless, when they are initially housed it is the most difficult time for them because social isolation often sets in. With our homeless clients, we have had them invite their whole encampment to their new place, or they have left their new place and gone back because they are just not comfortable being alone. For many people in CES, there is a program connected that will help them in that transition when they are housed. But I also believe that the proposal that Maria and her group has come up with addresses the isolation of homelessness and will help with the monetary side, too. It helps them in many ways to have more money, but the social isolation of being newly housed, not knowing quite what do with your time, and not knowing what you are going to do there—the program can help them with that.

4. **Question**: I like the overall model, especially the pre-booking element that is being developed and utilized through the county and system. But I have not heard anything about the re-entry program for the ex-cons and inmates that are coming back into society. What can we do for them, particularly for the ones with mental health issues and a need for a home and jobs?
    a. **Response:** There are several programs going on currently with jail in-reach, diversion, people leaving jail and supports there. That is why with innovations we are proposing has to be somewhat different. This is a pre-booking diversion program. We are actually trying to avoid going into jail in the first place. But there are many diversion programs in place right now for the population you mentioned. Certainly with CES, any population is eligible. It could be someone leaving the jail system; it could be our homeless veterans. There is a multitude of things that people are experiencing, and the population you mentioned could be included in the employment program as well.

5. **Question:** Not to disregard the pre-booking program, but as I hear you explain the program you are proposing it seems to me that it focuses on individual-level care. It does not address the population health level. It sounds like you have a mixed bag. The pre-booking seems to be a strictly individual care, but the housing and employment program seems to be a mix of both. With the social enterprise, I can see how that would have a more population health impact. But I am having a harder time with the pre-booking program. Do you have some comments regarding that?
    a. **Response:** I am not exactly certain that I understand your question. We will be focusing the health

neighborhood in a specific area in order to work a specific police department or law enforcement agency, and in this way build a relationship that when someone that is dealing with a mental health issue, then a team would respond and connect them to services. Yes, it is focused on an individual but it is within a specific community that will be trying to avoid booking someone that is suffering from mental health issues at the time of arrest and connecting them, during a time of crisis, to a service and not waiting and scheduling an appointment, but taking them to an urgent care system with a team and then being connected to services at that moment in time.

b. **Response:** This is really an identified population that is oftentimes arrested out in the community. The other part is the health neighborhood that will be built in terms of looking at the specialized population that continually has multiple arrest issues, goes in jail, exits jail and then lands in the community again without getting connected to treatment. This specific population is what we call "multiple users of the system" for lack of a better term. So even though it may seem individualized, they really are a target population that requires a health neighborhood to help support that re-entrance into the community and to deal with the multiple traumas of just being incarcerated because of the mental illness. The health neighborhood can help them become reintegrated into the community so that it does not continue to happen over and over again.

6. **Comment:** For many of the proposals we have to strengthen the language. As I read iterations of these proposals, what I understood to be really innovative about this, besides the community partnership, is the intention that the community provide the supports so that recidivism is reduced. We have not done this before, or done this well. Patty and I worked in Service Area 8 a long time ago on things that did not come close to this. That is why I think this is unique. Similarly, I think in the homeless and unemployment proposal the community takes responsibility. That will be the thread throughout all of this. That will be my job as I bring all of these proposals together to create a thread and link through all of the proposals. A proposal does not move forward unless it speaks to that.

7. **Question:** We really need to integrate those who are pre-booked or diverted into the community with connections to faith-based organizations and self-help support groups to end their social isolation so that they have a way of changing their behavior and not getting arrested over and over again. My question is about the middle proposal, the one we do not have in written format. This may be why I do not understand it really well, but from what I am hearing it sounds like it is an education program where we are educating the community. I am again playing the devil's advocate with the OAC: Doing a community education project does not sound innovative to me. What am I missing?
   a. **Response:** It is more of a community organizing approach to wellness with a focus on the use of cultural strengths. It is a 'community up' idea where we are going to identify natural community leaders and empower, educate, train and mobilize them for the overall wellness of an entire

community. It is more of a community organizing approach; not an individualized healing approach. It is a ground up approach where we are going to focus on the strengths of a community and a culture and provide services from that perspective.

b. **Response:** Okay. To me it sounded more like a mass media thing. So it is a ground up approach. That sounds great. That is fantastic. I love that.

8. **Question:** I thought this was going to be included in our proposal. I am concerned that things we brought up and that the community wants is not in this written document. So I am just hoping that will be corrected before that comes back here again.
   a. **Response:** The written piece will be brought back.

   b. **Response:** Any concerns you may have can be emailed to Debbie, Toby or Marcella. It may be in here and I have missed it, as I was just trying to provide an overview today. It is also a very difficult situation not having this written proposal and we appreciate your understanding. There was a mix up.

   c. **Response:** Thank you for acknowledging that. You already heard the concern of the misconception that people have about the proposal because it is not written down. We want just want to avoid confusion, so hopefully we will have this straightened out by the next meeting.

   d. **Response:** The proposal has already been submitted in writing. I did speak to community members about the content. I just did not present it in the proper way today, but you will get a copy for November's session.

9. **Question:** Two things you talked about don't sound innovative to me. The team that works with the police department--we have one of those, don't we? What do you call the team?
   a. **Response:** They are called PET and SMART teams, but this team is different than those. This is a pre-booking diversion and we have not implemented this idea before. We want to intervene before someone gets booked and serves time in jail. We are going to avoid that trauma from happening and they will be connected immediately to services. That is how it is different. It will not be a mental health clinician out with an officer when someone is having difficulty. It will be when an officer has arrested someone that has mental health issues and a team will go out to aid them and connect them to community resources immediately.

10. **Response:** That is what we had before we had PET and SMART. We already had those; a team of people, before they would get arrested. The other idea that sounds really good is the housing and jobs proposal, but I hope you are connecting people to employment where they will make enough money to make rent. Have

you checked the rent out there? Another program that I think would be very good to keep people from being isolated after being homeless, like one we had many years ago, is a center where they live or where they can go and do whatever they want to do.

11. **Response:** I think that idea can be presented directly to Maria and Wendy and see if it can be integrated or not. But right now we are commenting on what you have heard from the proposal.

E. Older Adults

1. **Comment:** I really liked your presentation, especially the idea of having mentorship and reaching out to the community and sharing the wisdom. I am wondering how that can be implemented concretely. I also liked the idea of having a neighborhood council. There is an ongoing thing at Loyola Marymount called restoring justice and that is a really good model that you might want to look into in terms of ways of resolving conflict within the neighborhood.

2. **Comment:** I think this needs to be pulled together more because it is still very broad. One of the suggestions I would have in terms of the health neighborhoods and community isolation is that many of the seniors have chronic health issues that need to be addressed. You can pull people into a self-help support group around that issue and that then helps to address the isolation and provides mentoring within the group. You can structure the group in order to do that. I would suggest that we make use of the medical conditions as a way of getting mental health support to people and thereby increase community integration. I also think that there are a lot of homebound seniors and that having a peer visiting component would be a way of keeping the isolation from happening, particularly if the peer visitors also met together and discussed things elsewhere, so if they had information to bring or topics of conversation to take to the homebound person it is not just, "How are you? My son is not talking to me. I hurt all over. I do not want to be here anymore." It is important to have actual news or topics to present or whatever.

3. **Comment:** I think neighborhood councils have a lot of potential. But one of the things that has come out of those neighborhood councils, as I remember, is the isolation of mental health consumers; it's like a form of ghettoizing of mental health. The neighborhood councils can be used for something that is very good and to endorse mental health consumers by advocating for their needs in their own communities.
    a. **Response:** As we see it, because this is supposed to be broad-based effort to impact the whole community here, we are not singling out anyone. It should be the whole community that is involved so that we have a broad community impact. We are looking at the whole population in an identified community.

4. **Comment:** I, too, like the ability to give back and the wisdom that we seniors might have. One thing that I feel is missing in the five proposals is faith-based organizations. At the beginning of this process several months

ago, someone who was a faith-based person said "Do not think of us as an add-on but really include us." I really feel that is one of the things that might be missing in all of these proposals and that would create a greater innovation.

5. **Comment:** I would agree that the homebound seniors are a little bit left out in this presentation. They do not attend community groups. They will not go to educational workshops, etc. I can send you some comments later but I do think that the most positive intervention I think anyone has ever seen in the research is not resolution of but rather prevention of elder abuse: it a friendly visitor program which is a very low cost, simple program.

6. **Response:** We can definitely incorporate the friendly visitor program. It is not hard to do and we can fold that in. As far as a faith-based component, it is part of this proposal but I hear your point that it should be more than a factor; it should be a significant factor. So we will have to see what we can do in that area as well.

7. **Comment:** I want to piggyback on the health conditions of the isolated, homebound senior. Maybe the only time they get out of that house is to be taken to a health appointment, per se. I can say from lived experience that primary care physicians do not ask the correct questions to determine if there is any sort of neglect or abuse going on in the home as well as what is going on with the seniors specifically. I think what is important in this process when we provide the community education is to really get the buy in from the primary care physicians and also your health agencies that specialize in treating seniors; to be able to know what to look for, ask those right questions and be able to read between the lines as well.

8. **Comment:** As you were mentioning the education campaign I kept thinking back to APS and the activities that they do. I would hope that as you continue to refine this proposal that you include some language that clearly defines how this is going to be innovative in contrast to anything that already exists or has already been done. The other piece that I thought about as you mentioned fall prevention and focusing on a community is "How great it would be if you looked at the physical environment as opposed to just fall prevention within the home?" You can look at the physical environment as you are looking at fall prevention. We are talking about light timing. Are they rushing to cross the street? Uneven sidewalks and those types of things.

9. **Comment:** Another suggestion is to help the caretakers. A lot of times the caretakers are so stressed out and isolated that that is where sometimes elder abuse can happen. Have groups and therapy or some support system for them.

10. **Comment:** I was going to mention the linguistically isolated as well. A lot of the Hispanic and Asian populations tend to stay at home if they are older adults. Then they are very isolated culturally and linguistically. So the in-reach into the home I think is a critical component. The other one to think about is a

	lot of the faith-based organizations have volunteers that do home visiting for people that are part of the congregation. So maybe tap into that as a natural resource, to utilize them, to help with visitors.
Public Comments	A. **Announcement**: There is an Asian Help and Recovery Meeting on October 29, 2014, in Alhambra, CA. It is by and for clients and is free to clients, family members and caregivers. Forms and flyers available. B. **Announcement**: California Association of Peer Run Organizations is offering a training in Santa Ana on November 7 and Ventura County on November 6. C. **Announcement**: Mental Health Services OAC meeting is on Oct 23, 2014. D. **Announcement**: The Alternatives Conference is on Oct 22 – 26, 2014. E. **Comment**: International Association of Peer Supporters has workshops on YouTube. F. **Comment**: Disability Rights of California and Each Mind Matters has a new publication out called "An Ounce of Prevention: Law Enforcement Training and Mental Health Crisis Intervention." Helpful information for adults.