COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, April 16, 2014 from 9:30 AM to 12:30 PM
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90026

REASONS FOR MEETING

1. To provide an update from the County of Los Angeles Department of Mental Health.
2. To report on the status of the Three Year Program and Expenditure Plan.
3. To form a new SLT Ad Hoc Workgroup to inform resources for the PEI Statement Initiative.
4. To discuss the planning process for future Innovation projects.

MEETING NOTES

Department of Mental Health Update	**Marvin J. Southard, Director, County of Los Angeles, Department of Mental Health** A. Dr. Southard updated the SLT on the triage grant from SB 82, CHFFA, the status of the Department's Laura's Law Proposal. He also discussed PEI statewide projects, the County's initial estimates on realignment and tax receipts for MHSA. He talked about the work on Health Neighborhoods, the award the Department won for a related project in South Los Angeles, the possible grant from the Blue Shield Foundation for Health Neighborhoods work and the development of partnerships with First Five Los Angeles. **FEEDBACK** 1. **Question:** During the last meeting, you discussed your conversations regarding mental health delivered through the Medicaid managed care programs and the issues around the expanded substance use treatment benefit. Where does that stand? a. **Response:** it has not really moved very much. The California Institute of Mental Health and the California Alcohol and Drug Institute merged. As of July 1st, they will be the California Institute of Behavioral Health Solutions. b. **Response:** The California Mental Health directors and the Alcohol and Drug Administrators are also merging. They will be merged by next September. The courtship was long and drawn. But the contracts are signed. c. **Response:** We are waiting on the state plan amendment and the waiver to get done. I have advocated at the state level for increased access to a drug Medicaid benefit with changed rates to the Short Doyle Medi-Cal providers. Anybody who is a Short Doyle Medi-Cal provider would have an easier access to getting a short–a drug Medi-Cal contract. d. **Response:** To integrate services really you need to integrate at the level of the community provider. Given the limitations, especially in LA County of the current alcohol and drug Medicaid network using the Short Doyle

mental health network is a template for that.

2. **Question:** Senator Ricardo Lara from Long Beach proposed a bill to insure the residually uninsured in California. Is there anything we can do to support that bill?
   Response: The bill is proposed less because it has any real chance of success and more to keep the critical issue of health benefits for people who are undocumented in the public eye. Realistically, we support that, but the financing is the issue. Even if it passed the governor would veto it. We support it because it is in the public interest if it were to actually happen. To be blunt, it is probably unlikely.

3. **Question:** Can you discuss the new awarded money for law enforcement and coordinating with DMH?
   a. **Response:** On the SB 82 side there are two components that connect with the law enforcement. The easiest to understand are the 15 positions related to law enforcement mental health response team. Our plan proposal is to dedicate 5 positions to the expansion of the SMART program that we run with LAPD, 5 positions to the expansion of the MET program operated with the sheriff who will match those with law enforcement officers, The sheriff plans to prioritize 3 of those positions for the Antelope Valley to expand the MET program there. Then we would use 5 positions for other communities.

   b. **Response:** In addition, there are forensic triage worker teams from the other part of SB 82. Those teams make linkages with people who are in jail. Those teams consist of somebody with lived experience of mental illness plus a clinician. It will be a contracted program. They will be linked to those providers who are already doing forensic work under AB 109.

4. **Question:** How about for the educational based incarceration program? Can any of that money be used to help these inmates?
   Response: No. The mental health dollars have to go to mental health clinicians. They cannot be used either with MHSA or SB 82 to fund law enforcement.

5. **Question:** Will there be more services for the jail mental health inmates with the money for DMH staff?
   a. **Response:** No, not in the SB 82 programs. Any growth for DMH staff within the jails would come from one of two places --realignment growth, or the Board of Supervisors will have to allocate additional county general fund resources for that purpose.

   b. **Response:** The sheriff and Department of Mental Health requested $30 million for the Board of Supervisors for expansion within the current jail structure.

6. **Question:** Is there data in terms of the age and whether the calls made to the warm line are people who are in care, have a provider or whether they are new cases?
   Comment: CalMHSA through Rand has been collecting some or all of the information that you just discussed.

7. **Question:** Who is the provider for the warm line? Is it a new or current provider?
   Response: Currently the provider is the DMH access. If we were to extend the program we would find a new

	provider. 8. **Question:** Is the warm line the access line? Or is it 2 different components where people call in? **Response:** There are two different numbers. But it is housed at the access line in the access center. I think 4 positions currently at access center are dedicated toward the warm line. 9. **Question:** It is the parent component that I'm concerned with. I know parents will not call the access line. I do not know if we are calling it the warm line and if it is being provided in different languages. **Response:** I do not know for sure. My guess is that we have Spanish functionality and English only. 10. **Question:** On the warm line, is this separate from Project Return's warm line that is in English and Spanish? **Response:** Yes. 11. **Question:** Is there a reason that we are doubling up? We do not have 3 suicide hotlines in LA County. Is there a reason we are not using Project Return to do the warm line? **Response:** Initially, it was CalMHSA that had the contract. They chose to contract with us to provide that through Access. Internally, within DMH, it would be better done by somebody else. So there would be a procurement process to determine who that somebody else would be.
Three-Year Program and Expenditure Plan - Status	**Debbie Innes-Gomberg, Ph.D., MHSA Implementation and Outcomes Division, County of Los Angeles, Department of Mental Health** **The Three Year Program and Expenditure Plan can be found on the LA County Department of Mental Health Website. FEEDBACK 1. **Question:** Is there consideration of putting metal detectors in the upcoming urgent care centers? a. **Response:** I do not know the answer to that. The urgent care centers are different than other programs. We can talk about Mary Marx about their construction. b. **Response** The urgent care centers that we have in mind through this are contracted out and will not be directly operated through the county. The procedures of that operating entity that determine whether they will have metal detectors or not. 2. **Question:** The increased FSP's of 480; is that exclusive of the 300 additional FSP's tied to Laura's Law? a. **Response**: It is inclusive. b. **Response:** So in addition to the Laura's Law slots there are only 180 new slots for adults? c. **Response**: I will check on that.

3. **Question:** With the urgent care centers I know initially the plan was set up to be kind of a 23 hour, 59 minute care center and many moved away from that because of funding. Will that model return to the new proposal of the urgent care centers?
   Response: The only one that is not 24 hours is the Long Beach one because of the particular difficulties of that provider. So we may be looking at the functionality of that provider in this new regime. But all of the other urgent cares will be LPS designated 23 hour facilities.

4. **Comment:** Right now the Three Year Program and Expenditure Plan is open for public comment. The next step will be May 22nd, our public hearing. I just submitted a special request form for the Board Letter for this process. We expect board approval by early July. What we want to do is use that group strategically to think about the next steps related to implementation of these programs. We'll be writing RFI's or RFS's where that is appropriate and engaging in the next steps.

5. **Comment:** I did read this. It is unbelievably accurate in terms of reflecting what the SLT did and the ad hoc committee. I think you and your team are owed major congratulations.

6. **Question:** Debbie you indicated that the public hearing will be on May 22nd. Will that be convened by the Mental Health Commission?
   Response: Yes

7. **Question:** I only have a comment about the Innovations. It seemed to me a little incomplete. Is that because you do not have all of the data in? There is very little information about the different cultural groups that are included especially in ISM.
   a. **Response:** We focused a little less on Innovation. What I wanted to do is make sure that you knew what the models and outcomes were that were emerging from the project. What is challenging about Innovation is that obviously it is a project with a time limit on it. What we present next year will be much more informative because it will really be at the point where it will inform CSS and maybe even a little bit PEI services going forward.

   b. **Response:** We expanded this group for a planning process. We did so very intentionally looking at different communities that were not well represented, in particular, SAAC representatives. A couple of people have emailed us and said, "Do we get to stay or do we have to go now?" The answer is that we want you to stay. The group has expanded in a way that is really wonderful. The group now is a stronger, more representative group. This is just the beginning of a planning process. It doesn't mark the end of it.

8. **Comment:** The SLT already has an 'Agenda Design Team,' we also have the 'SLT Ad Hoc Committee' which informed the Three Year Program and Expenditure Planning Process. We propose that instead of having multiple committees that we create one standing committee that informs the SLT agenda and implementation of the plan.
   a. Some of the ongoing tasks include completing work on SLT membership. We tried to bring in as much diversity, but there is obviously a need to go deeper into the demographics of who is here. How many of you are part of the department? How many of you work for contract agencies? The second item is following up on key items that we did not have a chance to resolve for the 3 year program and expenditure plan. Make sure that those are still on

the radar of the SLT and that we are addressing those. There was also a question of the grand agreement if you recall around the overall MHSA budget that we did not have a chance to complete. Finally, the third task is the Innovations planning process for the next round. Rather than create 3 different ad hoc groups and going to 3 or 4 different meetings, just one group and then within that group we can figure out who takes on what part, etc, and then just meeting regularly so that we are not having to schedule stuff in the last minute for a 3 or 4 hour session and all of that stuff. Any question about the proposal?

9. **Question:** I heard Debbie say they added service areas for the planning purpose. Do you mean that my argument with you guys for the past 4 years never was listened to?
    a. **Response:** Let me be clear about what the recommendation was that you put forward; that was to formally integrate a representative from the SAAC onto the SLT, right?

    b. **Response:** Right, 4 years ago, I'm pretty sure. But you just decided to do it when it was planning time, for planning purposes.

    c. **Response:** Factually, that's correct. That is what we did.

10. **Comment:** What we wanted to is, for example, that being one of the key issues, we just want to bring it back to the SLT ad hoc group, you all vote on it, that you formally want all of the SACC's to be represented and that let's move forward. We need to just tie that. But I think it is in everyone's interest that we want to have formal SAAC representatives here.
    a. **Response:** I know that. That's why I'm saying what I'm saying. So you did ignore me all of those years.

    b. **Response:** No.

11. **Comment:** I think the interest here is not only to formally incorporate SAAC representatives but other stakeholder groups that we need to consider.

12. **Question:** I'm in favor of both proposals. Though I think there are a couple of things that we need to take into consideration when we do this. We have a process of consensus as opposed to a process of voting. I felt that during our deliberations there was an idea that if we have 60% of the votes we should just go with that 60% and get it over with without listening to the other people. The reason that we do consensus is so the board of supervisors can't just pick and choose what they do. It is important that we have a balance of people. I still go back to the difficulty that I see when we have more than 60% of the SLT made up of providers, whether they be directly operated or private providers, that that could skew how our planning process and take away the richness and depth of what's going on.
    Response: On that point let me be really specific here about the 4 things that I'm referring to just so you see it. When we formed the ad hoc group we promised that it would begin and end. We do not want to do the bait and switch. What we are just trying to do formally is say that we want to form a standing committee that meets regularly. There are 4 areas that we want guidance on. One, we already set the next phase of the 3YPE plan, the 2nd is the Innovations project planning process, the co design of the agenda so that there is input from your peers around the priority areas on the agenda, and then finally, but very importantly, address other SLT internal items, including the consensus and recommendation making method, the membership, including the SAAC's,

	and a number of other internal stuff. 13. **Question:** I'm new to this process. Who will be on this committee and what are the criteria to be on the committee? **Response:** The criteria that we used were very restrictive and that was whoever wants to show up regularly. 14. **Comment:** I agree. Planning should be a part of a standing committee. **Response:** That's already part of our structure--the budget mitigation work group--so when the issue arises that gets activated. 15. **Question:** The concept of adding permanent SAAC representation and other representatives to the SLT in general would then be referred to the standing committee? a. **Response:** For example, the standing committee could come back next month and say, "Here's the proposal. Let's formally them and then let's do something else." That's where it would come from. That way the proposals are coming from you and your community peers as opposed to myself as a consultant. b. **Response:** So that means we wouldn't vote on that issue today. c. **Response:** Not today. We did not agendize it today. **VOTE RESULTS: 67% fully endorse it. 27% support it and 2% are neutral.** 16. **Public Comment:** In Memphis Tennessee they have a program, where they take the CIT (Community Integration Training) programs and have integrated it into the jails. I think that's something that we might want to do. a. **Response:** The District Attorney Jackie Lace, went to Memphis, looked at the program--so CIT is one of the models that we are looking at as a part of the implementation of that pre booking diversion program. CIT is a part of that because you cannot do pre booking diversion unless you train law enforcement about what their role in that process. 17. **Question:** The question of clarification has to do with the subcommittee or the permanent committee that we created right now. Is this open to everyone or just the SLT? **Response:** Since we were talking about turning the ad hoc committee into a standing committee it was an open discussion for those that wanted to attend. But there are two basic members. One were SLT members who are actively participating. We have the support of the age leads. So when it came time to making agreements only the SLT members were the ones who weighed in with that.
PEI Statewide Initiative Resources – Ad Hoc Workgroup	**Olivia Celis & Matt Wells** ** *A copy of the presentation was included in the April meeting packet.* FEEDBACK 1. **Question:** As a representative for the American Indian community, what information has been provided or will be focused

	on--we have such high rates of suicidality for our population. If I presented this to our groups is there any funding, planning efforts, or anything we can provide that could help support or be a part of the discussion? a. **Response:** The Native American communities are a focus group. There was just some activities that happened up north--some learning collaborative--there are materials that are being created. I do not know if any of you have seen the Documentary, 'A New State of Mind,' there is a vignette in there that has Native American. Eventually there will be 40 vignettes on there that agencies can use to promote mental health, stigma and discrimination reduction and suicide prevention. b. **Response:** This committee will help us figure out how we purchase the materials and disseminate. If you are talking about the physical materials that people can use to disseminate brochures, posters, things like that, that's what this group would help put together. 2. **Question:** Will you create any materials in sign language for the deaf and hard of hearing population? **Response** That has not been on the table but is something that LA can start providing feedback on. 3. **Question:** I'm wondering who the website, "suicideispreventable.org" is targeted at? **Response:** It is really targeting caregivers and people around potential suicide attempters. 4. **Comment:** The work group will help us structure and categorize and collect all of this information that Dennis is talking about. So that's the work of the work group. 5. **Question:** I am hoping that we will outreach to the UREP groups that are doing some things such as the Ethiopian communities, public health coalition, which have written some of their own outreach and engagement material. I've learned through the initiatives that DMH has done that cultural competency and a sense of engagement of the communities is different. Inviting them to the table would be a good idea. **Response:** I wanted to recommend that the CCC be part of this work group as well as the UREP sub committees and also the SAAC's because these are the people that go out and do the outreach and engagement and so forth. 6. **Comment:** Also invite the Gay and Lesbian centers because there is also a high number of suicide among the GLBT community.
Planning for Future Innovation Projects - Discussion	**Debbie Innes-Gomberg, Ph.D., MHSA Implementation and Outcomes Division, County of Los Angeles, Department of Mental Health** A. Starting in fiscal year '15-16 three of our four innovation projects will have sunsetted and we will have learned from those projects and maybe will have funded the more successful ones. You can't start soon enough planning for the new innovation projects. I'm going to do two things today. I'm going to first just orient you all to the components of Innovation, what an innovative project is. Then, second, I want to ask you, "What do you want to learn?" B. An Innovation Projects is a project that the county designs and implements for a defined period of time --the draft regulation stipulates not to go beyond 4 years, and evaluates new best practices in mental health. It meets one of the following criteria (it may be one or more): It introduces as a new approach or an approach that is new to the overall

mental health system, including but not limited to PEI. They put the PEI part in here to help us think that maybe an Innovation project could inform PEI.

C. Second, it makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population.

D. Three, it introduces a new application to the mental health system or a promising practice or approach that's been successful in a non-mental health context.

E. The reason we created this template is that it clearly maps out how a project meets the criteria for innovation. Specifically the project is expected to contribute to the development and evaluation or a new or a changed practice within the mental health field. It describes the population to be served. The primary purpose: the county shall select one of the following purposes for developing and evaluating a new or changed mental health practice. It increases access to underserved groups. It increases the quality of mental health services, including better outcomes, so something that is quality driven. It promotes inter agency collaboration related to mental health services and supports and increases access to mental health services.

F. The focus on mental health in an innovative project may affect virtually any aspect of mental health practice or assess a new or a changed application of a promising approach to a solve a persistent, seemingly intractable mental health challenge. Stakeholder involvement is essential in this process.

G. Evaluation is a large component of innovation. Many of you know that UC San Diego is doing our current evaluation of the innovation projects. We will be required to articulate our learning objectives as well as our approach to evaluating each Innovation project.

FEEDBACK

1. **Question:** What are the start and deadline dates for this project in terms of new innovation projects?
   Response: The earliest start date would be July 1, 2015.

2. **Question:** If you were to work backwards, Debbie, in terms of issuing the RFP or RFQ, if we wanted to get the funding out by July 1, what might that look like?
   Response: Now. One of the reasons that this is a challenge is that the money starts accumulating and you do not want to get into a reversion situation. The sooner we can get these projects out the door and funded and started the better off we are.

3. **Comment:** Given that timeline the standing committee would weigh in on how long do we want the planning process to be, when do we want the planning process to end with a recommendation for innovations projects, so depending on when you want to get the money out the door--all of that will be part of that standing committee.

4. **Question:** How much money are we trying to get out the door?

Response: On average we get about $19 million a year for innovation. 5% of that comes from CSS. 5% of it comes from PEI.

Peer and Group Discussion Report Backs

5. **Comment:** Employment, moving people out of the seventh floor of the jail into intensive community services, and also pre criminal system diversion that is not to an IMD, and making waiting rooms into recovery rooms. Rather than having everybody sit there, bring people from wellness centers into the waiting rooms to talk to people about programs that they can get involved with elsewhere and have this group work on getting jobs furthering their education and this group talking about bipolar issues and this group dealing with all this other stuff.

6. **Question:** What are those questions? What do you want to learn?
   Response: We want to learn how to get people employed--increasing employment--because that's part of recovery. We have a dismal 2% employment rate in our system.

7. **Question:** For the other one you mentioned, the criminal justice system diversion, what was the question that you are interested in there?
   Response: How do we get people out of the jail and into the community? How do we get a really strong, whether it is an FSP, but it needs to be really strong, in terms of keeping people out of--community re-integration.

8. **Comment:** A possible Innovative project would be creating a place where parents and their children learn socialization skills. As parents with special needs children, mental health or whoever, we lose that socialization because we are ostracized, put on the side, or just cannot go out there and The child with the concern is also it is very hard for them to learn how to socialize.

9. **Question:** Is the learning about strategies to increase socialization or is it what?
   Response: I think it is strategies but also socialization itself. If you have a location where parents are going to learn how to socialize it is a group of parents going so they will learn how to socialize with each other and get to know other parents and children. They work together with their children.

10. **Question:** So, "In what ways can parents and children work together, with each other, to increase and improve socialization skills?"
    Response: Right.

11. **Comment:** So that's the question and maybe a strategy is a place where that can happen.

12. **Comment**: What came out is only TAY, adults, and older adults were funded under those programs. We advocate looking at children and families to be included in this coming round.

13. **Comment:** So there I'm not hearing necessarily a new question but rather the interest of the children, making sure that they're included in this next round.

Response: Right. The next one is in attending these meetings often what is mentioned is that an EBP isn't culturally relevant. To really look at programs that are promising practices that are culturally relevant that could become an EBP.

14. **Question:** In what ways can culturally relevant promising practices be supported?
    Response: The last one is the need for better linkages. If it is something that's already happening in one area that's strengthened. Like employment, it might be strong in one geographic area. We can connect them to the other areas that are weaker in that area and how to connect them so that they're not reinventing the wheel

15. **Question:** "In what ways can we identify effective practices in one area and disseminate them in another area? A project that helps us understand how to do that quickly, efficiently, and effectively.

16. **Comment:** My lesson to be learned comes from my experiences lately in the county committees and on the state committees. A lot of people have been talking from the different cultural groups that I see on those committees. They talk about historical traumas and experiences of the different cultures. What I'd like to learn, is how those historical experiences are related to the present day mental illnesses that those different cultural groups demonstrate like suicide, stigma, other behavioral problems.

17. **Question:** So how are historical traumas and experiences manifested in today's experiences and their link to effective treatment and support for those?
    Response: Yes.

18. **Comment:** Can we explore ways of finding the most chronically mentally ill and having a plan for them before they are discharged from the hospital and possibly at least housing for 10 days until they can get back on FSP or other services? There are all of these gaps; so just a study of that, and then placing money and helping these people. It is costing everyone a lot of money, the county, and costing more illness, deterioration and brain damage.

19. **Comment:** I just want to affirm that the persons you are referring to are precisely the ones that we want to target.
    Response: Especially the co-occurring that have both disorders because that makes it even more dangerous.

20. **Question:** So those persons can be exactly those that we target. So I wanted to affirm that. The second thing I heard is that there is a particular juncture upon discharge where there is a lot of vulnerability and gaps. So you are interested in, "To what extent can we understand what that experience is like so that we can intervene more effectively in that time period?"
    Response: All we have in LA County is a few people that are assigned, liaisons, but they're not doing it. There is no interim housing.

21. **Comment:** I have four different proposals. The first is about the substance abuse issues. Our experience with the ISM's, we were thinking in terms of we need to have culturally adapted engagement strategies for the underrepresented groups. There are not enough. One of the things that he has found is that once they are engaged they actually do fairly well in many of the programs. We were thinking of course this overcomes the stigma. You have to overcome the stigma

of communities. There is a lot of stigma. They do not want to even admit they have substance abuse. The other issue is of course the pathological gambling for API's. That's number 1.

22. **Comment:** We need to tease out what we are learning from the current innovation project and apply to a future one. Number 2 is something that has come out of our planning and also out of the SAAC's is also the concept of UREP wellness centers--the centers without walls concept. Wellness centers are brick and mortar focused. You can use community-based organizations to provide a wealth of wellness activities and services at a much lower cost. The third idea is from service area 5, which needs more intensive homeless outreach, not in the downtown centers, not in Santa Monica where they are gathering, but actually in the neighborhood parks. Finally, we want to develop a focus group or commission that looks at ways to retain our staff.

23. **Comment:** The UREP leadership group talked about developing the next initiative around healthy neighborhoods and aftercare models that address issues around what we do with families and how we connect them to services and integrate them into the new healthcare system. A component of that has to be education. A lot of people are not connecting because they do not know what is available, what can be done and how it can be done, so linking them to these services and seeing how that works with it, and then after they get services, making sure there is someone that go and connect to make sure we cut done the number of re-episodes that go on in the community because there is nowhere to connect after something happens or after they get services. I think we need to work on a model that does that and we need to make it culturally relevant and competent in how we engage the community at the community level.

24. **Comment:** In your group if you could think about what the learning questions and what you hope to learn. I love your ideas. I think you just need to think more about what the learning questions would be.

25. **Comment:** I want to follow up on Nina's suggestion about EBP's and I guess what I want to learn is if the county can become entrepreneurial or not. Can the county put in an investment in promising practices, particularly as related to underserved groups that are not otherwise targeted for EBP's, put the investment in, create the EBP, market it and then reinvest the money back into the mental health system?

26. **Question:** Are you thinking that the department would be a developer?
    Response: Yes. A lot of that would be in your department because you are set up to do that anyway. We would take promising practices, measure then, develop them, whatever you have to do to turn a promising practice into the package which we now call evidence based and then some other place would market them for the county and that money could come back into the mental health system.

27. **Comment:** The intellectual property holder is still the county although you can hire someone else as the developer.

28. **Comment:** Creating an outreach and education program for deaf and hard of hearing people using sign language. Currently there is nothing like that. We have a huge disenfranchised population. LA has one of the largest populations in the world of deaf and hard of hearing. 10% of population [inaudible]. There is no outreach in our language that ASL users can understand. Studies show how many deaf and hard of hearing people need mental health services so it is very difficult to set up a program.

29. **Comment:** We had a very focused discussion on reaching out to our boys of color. We thought about what age span we could focus on but really there are place based initiatives that are out there that are not, in my opinion, working at this point. There are good efforts, great programs that we are discussing with the group here but we have these alarming rates of youth being pushed out of high schools. We have incarcerated, there is probation, and there are recent studies that are indicating that a lot of our youth have more symptoms of PTSD that are vets that are coming back from the Iraq war. This has been an historical issue. It has not been something that has emerged in the last decade. It is been going on for years, whether you want to call it from a structural racism point.

30. **Question:** "How can we improve our access through outreach and engagement to our un-served or underserved boys and men of color?" Let's identify some best practice approach that utilizes the prism from a male's approach that incorporates non traditional healing practices to our young boys and men and as well as just building capacity with partners who are directly involved with the boys and men of color, whether it is the public defender's office, even through the universities, and local CBO's. I've been in directly operated mental health facilities for a long time.

31. **Comment:** How do we expand the awareness of the interfaith component so that we are reach deeper into the communities where we can identify the boundary between pastoral counseling and the need for mental health services and where we potentially have cultural issues that go back hundreds of years or more that are belief systems rather than things we are aware of?

32. **Comment:** Mine is a justice involved program for TAY and adults. We start with EBP, such as critical time intervention and crime [inaudible] and create a homegrown EBP here. Ex felons and people that are involved with criminal justice have less access to employment obviously, to housing, to healthcare, and substance abuse treatment. It would be a whole person approach, recovery rehab based, and we would use employees, the staff, a large number of people who were themselves formerly incarcerated.

33. **Question:** The questions would be, "Can we reduce recidivism?" One third of men and women that come out of prison go back to prison within the first month. "Can we show the taxpayers how many dollars they will be saving by programs like this?"

34. **Comment:** My question is, , "When and how will the department start to train staff from top to bottom [inaudible] people that come into the clinics?" And I mean from the security guard to the clinician, People have no idea of who they serve and how to serve them. We need to get in there and train anyone that comes into a mental health facility of the proper way and what they will be dealing with.

35. **Comment:** I want to address the needs of what I consider a very underserved population --the Central American community in central city. I work for LA Unified and our focus is children. As part of our CBITS (Cognitive Behavioral Intervention in Schools) study, over and over again we found that there were trauma rates of over 90%. We worked on CBITS with the Rand Corporation. It got to the point early on that they were telling us, "Redo the questionnaires. This can't be right." Over and over again we find these high incidences of trauma in our school communities.

36. **Comment:** But I'm jumping from that to a very specific underserved population and that is the Guatemalan Indian

community. These Guatemalans have experienced historical trauma. In the early 80's they were the subject of genocide and extermination. It is believed that there are over 800,000 Guatemalans in LA County, the largest population outside of Guatemala. These people do not speak English or Spanish. They speak their native language. There is a lot of trauma. I'm a volunteer.

37. **Comment:** What you are proposing here is a particular population, a smaller ethnic group, that might be a place where we can—
    Response: --Outreach to this community probably with interpreters.

38. **Question:** So perhaps the learning question is, "In what ways can the outreach occur more effectively with that population but also when you do outreach what is the most effective approach to the historical trauma as it is being experienced by them?"
    Response: Correct, thank you.

39. **Comment:** I want to speak to the needs to homeless mentally ill. In order to have success in interim housing and with the homeless outreach you need to have permanent solutions. The department of health services, this year, has implemented something called Housing for Health in which they provide rental subsidies and very intensive supportive services. The department should consider participating in that and finding a way that to expand work with the homeless, severely mentally ill, that both are being discharged and in interim housing. And if you are going to do outreach you need a place to help get people stable.

40. **Comment:** We need support services for those exiting out of institutions such as who are released from custody-- incarceration facilities, linking them to treatment. We need to increase actual transportation and support services for such people in the form of a warm hand off to after care, some sort of residential treatment. It just does not exist. It is not adequate. The question is, "Will increased linkages and supports for people who are released from the jails decrease recidivism for those who are co-occurring diagnosed?" To increase awareness and education in a very focused way around LGBT issues for our UREP communities and health neighborhoods, again very focused in terms of ethnic and culturally specific populations, to reduce stigma, suicidality. Will it decrease homelessness for those that are so afflicted? Maybe increase a bridge to those existing LGBT service agencies.

41. **Comment:** My question, "Is there a way for us to increase support for more linkage to transportation?" Can we create something where there is support for youth, the parents, anybody to be able to get to the appointments?

42. **Comment:** Another county got an Innovation project approved by the MHSOAC in the last several months or so was around a rural county and innovative uses of public transportation.
    a. **Response:** For example, the Antelope Valley, it is huge.

    b. **Response:** I think one of the things that's a problem with a lot of that are being said is that the question that we, the OAC, are going to ask is "Where is the innovation here? Why is this different?" These things all exist. If you are going to look for innovation you've got to say, "What will make this unique?" This is my argument with the innovation program from the beginning: they got committed way too fast. They did not allow for the genius person

to pop up with an idea that was really innovation.

43. **Question:** The Cultural Competency Committee is interested in asking, "How does the acculturation process affect current mental health, symptoms, treatment, and the involvement in treatment and so forth?" We are interested in different levels of the acculturation process and how that affects the families, family interaction, and treatment. Our group is thinking about, "How can we use leadership skills, some of the techniques that are used in the business world such as creating leaders, how to sell yourself, and how to improve self esteem and mental wellness?" How can we work more interactively and collaboratively with faith based organizations as well in the business world?"

44. **Question:** In intensive case management we learned that we could keep people out of jail, back out of the hospital, by having a lower case load and meet the people wherever they were. "How do you make sure you link everybody that has a mental illness coming out of jails and hospitals to something without just turning them loose?"

45. **Comment:** Parents in the community get referred to parenting classes for a variety of reasons, including dependency and delinquency, education; others are just community--ancillary to mental health treatment. Parenting classes are notoriously ineffective in terms of improving actual parenting skills. My question is, "Can we look at innovating a different way to teach parenting skills in a group but does not follow the standard parenting class curriculum model?" Develop a program that coaches parents to respond to their kids in a more empathic manner and can actually do pre and post testing to demonstrate improvement, and could be performed by paraprofessionals and not by mental health professional.

46. **Comment:** What would it look like if we were to create a team that involved fire, police, specific medical professionals, and mental health professionals that looked at the high rate of recidivism of the people in and out; to get all of them together to not only identify these individuals, but having them, including fire and police, actively involved in the treatment process and decision making to engage these individuals in the decision-making process. This team can work together to actively involve and outreach to these individuals once they are released into the community.

47. **Question:** In my service area about 55-60% of referrals from DCFS are under the age of 5. I do not think we have a good enough handle on what we can do to effectively treat the 0-5 year olds and more specifically the 0-3 year olds. My innovation proposal would be to look at if there is anything we missed in terms of a 0-3 year old EBP which we do not currently have in LA County and/or promising practices that we could put into place to see if they would rise up to an EBP. Also, how do we measure progress and outcomes for these really little ones? We can't measure homelessness for a 3 year old. So what do we measure to show that we've actually moved this child and their family members in a forward direction?
    a. **Response:** You need to talk to LA Child Guidance. They have a nationally recognized 0-3 specialty.

    b. **Response:** That's not a DMH EBP.

    c. **Response:** I understand that. You just need to broaden your horizon.

48. **Comment:** In the healthy neighborhood model I want to add to the list besides the UREP, the LGBTQ community as well as the deaf and hard of hearing and maybe even the blind community, so that we can see how we outreach and engage

	them around healthy neighborhoods as specific communities in this and the aftercare approach as well. 49. **Comment:** Some of what I heard in terms of proposals and ideas related to really key issues moving forward. The role of people moving out of institutions, the role of providers, practices, and outreach and engagement, transportation strategies and all of those things--that is really important. Senator Steinberg's office contacted me earlier this week to talk about, "How do we do those?" We looked at the outcomes for the adult FSP programs as it relates to recidivism and we were looking at specific providers. We are going to bring Senator Steinberg's chief staffer down to take a look at some of the programs. That seems incredibly relevant. It is also relevant to SB 82, the CHFA program, as well as the triage personnel. As you develop ideas think about how we are not going to replicate what is already occurring in this area.
Public Comment	1. **Announcement**: Monday: a call from the national mental health consumers self help clearing house. 2. **Announcement**: May 4 in Orange County, a nationwide demonstration. 3. **Announcement**: Dental Clinic announcement