

Continuous System Improvement Committee

April 16, 2015

Double Tree Hotel
2800 Via Cabrillo Marina
San Pedro, CA 90731

Santa Rosa Room
8:30 a.m. to 12:00 p.m.

Item #	Time	Topic	Presenter or Facilitator	Tab
1.	8:30 am	Planning Council Members Issue Requests	All Members	
2.	8:35 am	Welcome and Introductions	<i>Susan Morris Wilson, Chair</i> <i>Lorraine Flores, Chair-Elect</i>	
3.	8:40 am	Review and Approve January, February Minutes	All Members	A
4.	8:45 am	Update: Preliminary Data Notebook draft, proposed questions	<i>Susan Morris Wilson, Linda Dickerson</i>	B
5.	9:45 am	Break		
6.	10:00 am	Update: OAC research update; CMHPC and OAC Priority Indicators Joint Task Force	<i>Renay Bradley, Linda Dickerson</i>	
7.	10:15 am	Update: New Community Forum report, and Approval: revised 2014 Trauma report	All Members	C
8.	10:30 am	CSI Committee Work Plan 2015	<i>Susan Morris Wilson, Chair</i> <i>Lorraine Flores, Chair-Elect</i>	D
9.	11:30 am	Public Comment		
10.	11:45 am	Evaluate Meeting/Develop Agenda for Next Meeting	<i>Susan Morris Wilson, Chair</i> <i>Lorraine Flores, Chair-Elect</i>	

The scheduled times on the agenda are estimates and subject to change.

Committee Members:

Co-Chairs: Susan Morris Wilson – Chair Lorraine Flores, Chair-Elect

Members: Patricia Bennett, PhD Raja Mitry
Renay Bradley, PhD Monica Nepomuceno
Kathleen Casela Noel O’Neill
Amy Eargle, PhD Walter Shwe
Karen Hart Bill Wilson
Celeste Hunter

Staff: Laura Leonelli Linda Dickerson, PhD

Continuous System Improvement Committee Charter

Overview

The California Mental Health Planning Council (CMHPC) is mandated by federal and state statute to advocate for children with serious emotional disturbances and adults and older adults with serious mental illness, to provide oversight and accountability for the public mental health system, and to advise the Governor and the Legislature on priority issues and participate in statewide planning.

Purpose

The purpose of the Continuous System Improvement Committee is to monitor, review, evaluate, and recommend improvements in the delivery of services in the public mental health system in California. By highlighting and recognizing outstanding service delivery programs, it is hoped that effective care can be duplicated and shared throughout the State of California.

The CSI will consider programs across the lifespan, incorporation of cultural competence in all programs, fiscal impacts on service delivery, legislative issues affecting programs, and other issues that may require attention as they occur.

Mandate

5772. The California Mental Health Planning Council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:

- (a) To advocate for effective, quality mental health programs.
- (b) To review, assess, and make recommendations regarding all components of California's mental health system, and to report as necessary to the Legislature, the State Department of Health Care Services, local boards, and local programs.
- (c) To review program performance in delivering mental health services by annually reviewing performance outcome data as follows:
 - (1) To review and approve the performance outcome measures.
 - (2) To review the performance of mental health programs based on performance outcome data and other reports from the State Department of Health Care Services and other sources.
 - (3) To report findings and recommendations on programs' performance annually to the Legislature, the State Department of Health Care Services, and the local boards.
 - (4) To identify successful programs for recommendation and for consideration of replication in other areas. As data and technology are available, identify programs experiencing difficulties.

(d) When appropriate, make a finding pursuant to Section 5655 that a county's performance is failing in a substantive manner. The State Department of Health Care Services shall investigate and review the finding, and report the action taken to the Legislature.

(e) To advise the Legislature, the State Department of Health Care Services, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.

(f) To periodically review the state's data systems and paperwork requirements to ensure that they are reasonable and in compliance with state and federal law.

(This is only a partial list of all the CMHPC's mandates)

Guiding Principles

Committee policy and strategy recommendations should reflect and strive to address the following priorities:

- 1) Focus on improved outcomes for clients and their families.
- 2) Best practices and continuous quality improvement
- 3) Culture and linguistic competence
- 4) Promotes a client/family/parent driven system
- 5) Reduces stigma and discrimination
- 6) Emphasize the inclusion of all ages across the life-span
- 7) Aimed to reduce mental health disparities
- 8) Promote total health integration

The committee is made up of a chair-person, vice chair-person, and members. Currently, the committee consists of the following members.

Continuous System Improvement

Name
Susan Wilson, Chair
Lorraine Flores, Chair-Elect
Patricia Bennett
Kathleen Casela
Amy Eargle
Karen Hart
Celeste Hunter
Raja Mitry
Monica Nepomuceno
Noel O'Neill
Walter Shwe
Bill Wilson

_____ **INFORMATION**

TAB SECTION A

 X **ACTION REQUIRED:**
Approve Minutes

DATE OF MEETING 4/16/15

**MATERIAL
PREPARED BY:** Leonelli

**DATE MATERIAL
PREPARED** 3/10/15

AGENDA ITEM:	Approval of CSI Committee Meeting Minutes
ENCLOSURES:	<ul style="list-style-type: none">• Minutes of CSI Meetings on January 15 and February 24, 2015
OTHER MATERIAL RELATED TO ITEM:	None

ISSUE:

Continuous System Improvement Committee review and approval of minutes from January Quarterly meeting and February In-between teleconference.

No meeting was held in March, 2015

Continuous System Improvement Committee

Meeting Highlights

Thursday, January 14, 2015

**Crowne Plaza San Diego
2270 Hotel Circle North, San Diego, CA
Paradise Room**

Committee Members Present:

Susan Wilson, Chair
Lorraine Flores, Chair-Elect
Karen Hart
Celeste Hunter
Raja Mitry
Noel O'Neill
Walter Shwe
Bill Wilson

Staff Present:

Jane Adcock, EO
Linda Dickerson, PhD
Laura Leonelli

Others Present:

Beryl Nielson, CALMHBC, Napa County Marcia Ramstrom, CALMHBC, Shasta County
Mae Sherman, CALMHBC, Lassen County Luvenia Jones, CALMHBC, Alameda County
May Farr, CALMHBC, San Bernardino County Sheridan Merritt, MHSOAC
By Phone: Renay Bradley, PhD, MHSOAC Cynthia Burt, Consultant

Welcome and Introductions:

Chair Susan Wilson welcomed those present, who all introduced themselves.

Review and Approve October, December Minutes: The minutes were reviewed and no amendments were offered. Motion was made by Noel O'Neill to approve minutes of both meetings as written; motion seconded by Bill Wilson; motion passed.

Discussion: a) Preliminary Data Notebook report – Printed copies of the report were distributed to all those present for review. Linda Dickerson obtained a 67% response rate from counties through persistent contacts and reminders; the current draft version represents data from over half the state's population. LD explained the process of compiling information by topic, and how county responses were compared within each topic. The questions for last year's Data Notebook included issues of access and client retention, data collection and service outcomes, participation by under-served communities, wellness and physical health linkages, and consumer perceptions of service effectiveness. This is good basic information that helps Mental Health Boards to get a better understanding of their local MH system. Further review and comments are welcome. The electronic version of the Data Notebook will be sent out to members and responses should be submitted by Friday, January 30, 2015.

b) New topics for future reports – Several topics were suggested and discussed, including the intersection of mental health and the Justice system. No decision was made, and the

Committee may want to coordinate this year's topic with other ongoing data analysis efforts. More discussion on Data Notebook topics and questions will be resumed through the monthly In-Between meetings/ conference calls. We will invite members of the former Data Notebook Workgroup to participate, and will include members of the CALMHB/C. A reminder that the CA Behavioral Health Directors Association is working on having all counties post data reports on a 'dashboard' – the focus will be on 5 themes emphasized by the Center for Medicare/Medicaid Services.

Discussion: OAC research update; CMHPC and OAC Priority Indicators Joint Task Force –

- a) Renay Bradley requested that members of the CSI Committee volunteer to serve on the Advisory committee for the Recovery Orientation Program evaluation, the lead researcher is Dr. Todd Gilmer of UC San Diego. Several members expressed interest.
- b) The results from the TAY program evaluation work group will be released in a few months. The lead researcher from UC San Diego, Dr. Gilmer, has shared draft reports. Lorraine will help present the results at a future Quarterly meeting. Another project will be evaluating evidence based practices for children and families. The lead is Cary Masten from OAC and he is seeking subject matter experts on this topic.
- c) The MHSO Oversight and Accountability Commission (OAC) is working with the Department of Health Care Services to strengthen state-wide data collection. Renay will present the overview at the OAC meeting next week. UC San Diego researcher Dr. Andy Sarkin is working with OAC to identify standard indicators for adults in the Continuing Systems and Supports projects. The OAC and DHCS are submitting an Advance Planning Document for a new IT system based on this planning effort.
- d) Priority Indicators are important instruments for measuring outcomes, and the CMHPC has a statutory mandate to approve them. Susan Wilson, Karen Hart, Walter Shwe and Lorraine Flores represent the CMHPC on the Joint Task Force, and Raja Mitry expressed interest in participating. Linda Dickerson is one of the project leads. Kate Cordell of UCLA is contracted to do this research for OAC. Sheridan Merritt shared the questions that frame this data collection effort: How well is the system working? What outcomes and trends are resulting from mental health services? What are the basic indicators of consumer progress? What areas need more data? Handouts were distributed that summarize the process for identifying, developing and implementing new or revised performance indicators.

Panel Presentation: Juvenile Justice and Mental Health in San Diego

Dr. Geoff Twitchell, Treatment Director, San Diego Probation Department – San Diego is the only county that has a Treatment Coordinator, he works with both adults and youth. Evidence-based practices are used with youth in custody. Diversion programs have resulted in 30-45% fewer youth in the justice system over the past 10 years. As a result, the youth entering the system have the most serious behavior issues. The Chief of Probation has emphasized trauma-informed services, and has mandated 4 hours of training for all staff in both probation facilities and field services. PYJI is only one effort in a process to change the treatment system, making it more productive and less defensive. Treatment

is provided in Juvenile Hall for specific mental health issues, and youth are prepared to continue treatment in the community upon release. Functional family therapy is provided to parents of youth both in and out of custody at their homes. There is a shortage of treatment facilities in the county, with the result that some youth with mental illness are placed out of state for treatment. As an alternative, youth can be placed for 6 months with trained foster care families, then return to families and community. 8 hrs of suicide prevention training will be provided to all staff in February, on best clinical practices. Room confinement increases risk by 50%, they are exploring alternatives. Question: are there school resource officers? Only one, the officer is funded by a school district.

Anissa Harris, Supervising Probation Officer: Ms. Harris coordinates San Diego County's Positive Youth Justice Initiative program. The grant is funded through October 2015. Staff includes 2 Probation Officers, a Marriage/Family Therapist, and a Juvenile Recovery Specialist who all receive trauma-informed training as part of the program design. There are 37 participants from 13 to 17.5 years of age; the project is funded for 50. Selection criteria include residence in 8 specific zip codes, prior contact with the child welfare system, as well as current probation status. Program components include Family Involvement Team meetings to determine a case plan, weekly home visits, and a parent support group. Parents are often resistant to changing their own behavior, or taking a proactive role in their child's rehabilitation. Parents can receive certificates for completing the program. Some youth may be able to end their probation early through participating in the program. The Breaking Cycles program uses a WRAP approach for youth offenders with mental health needs and will hopefully continue after the PYJI grant ends. The Initiative has helped to change the way probation services are provided across the system. Question – How is parent participation encouraged? The staff has built good relationships with the parents, and the meetings are in familiar community locations with easy access. Question – Are cultural considerations, such as stigma, included in the parenting component, and how are they delivered? The Department has cultural community partners who help provide this service.

Tami Burns, Supervising Probation Officer: Ms. Burns oversees the Juvenile Forensic Assistance for Stabilization & Treatment, commonly referred to as JFAST program. This is a diversion program for youth aged 6 – 17 yrs who are high need with serious mental health issues. The youth receive mental health assessment at intake; some have dual drug/MH diagnoses. She also works with the Community Assessment Team (CAT) which is a targeted prevention program involving 5 collaborative agencies. JFAST is a diversion program, a collaborative Court that meets weekly and includes the public defender, the District Attorney, and mental health services providers. 2 Probation Officers supervise 15 – 20 youths each, the emphasis is to keep them in the community and out of residential treatment. If youth successfully complete the program and rehabilitation their court records are sealed for 5 years. She distributed a program overview, a program information brochure, and a graphic of their Comprehensive Strategy, which includes prevention as well as graduated sanctions.

Question - Is there collaboration with Family Court mediation services? Sometimes; the JFAST program provides WRAP services and these can overlap with Family Court and the District Attorney's office if the family is involved with them.

Question - Do children participate in the decision-making? Yes, through the WRAP services and the child is part of that process.

Nancy Gannon Hornberger, CEO Social Advocates for Youth (SAY): Prior to this position she was the Director of a national organization, the Coalition for Juvenile Justice, for 22 years. She started as clinical services provider in special education for court-involved kids 12 – 21 yrs, and used a social ecology model that addresses individual needs in context of family, community and systems. Programs at SAY emphasize the same approach. In 2000 she contributed to the Mental Health Needs of Youth report to the President and the Legislature, that highlights WRAP, multi-systemic, and functional family therapy approaches and recommendations. Her organization influenced Federal policy resulting in the proposed Whitehouse/Grassley amendments that recommend comprehensive mental health screening, assessment and treatment at every level of court involvement. The CA Bureau of State and Community Corrections (BSCC) funds local delinquency prevention, alternative sentencing, and brief interventions. There is a connection between federal, state and local policies. She distributed the SAY 2014 Annual Report that described their prevention, day treatment, and other programs. They provide a continuum of services involving community partners, the Probation Department and Child Welfare. What San Diego provides through their community collaborative: 25 yrs ago there was deliberative effort to pursue comprehensive juvenile strategy (handout distributed). The emphasis of county resources and funding is on prevention, for all at-risk youth populations. All these efforts impact the reduction in delinquency and incarceration. There is a shared commitment to cultural competence, trauma-informed approaches, and providing treatment in the least restrictive setting.

Question: In Santa Clara they are developing High-end juvenile justice homes for older adolescents. Those are often the youth who are sent away, there are things that can be done to improve the system. Now San Diego can address the high-risk high needs population and they don't have to be sent to out-of-state placements.

Question: How do providers as well as parents get Trauma-Informed mental health care and training? The emphasis should be on family support, family strengthening. Program staff who have lived experience are vulnerable to secondary trauma, and need self-care. This goes beyond just training. Support groups include Family and Youth Roundtable who provide expertise and assistance.

Nancy will send LL the Family Justice Alliance report, to distribute to Committee members. This resource outlines experience of families with children in the juvenile justice system, some who experienced suicide and other traumatic experiences, and includes recommendations for individual treatment, family engagement, and policy changes, since current policies create barriers to family involvement.

What can collectively be done to promote trauma-informed approaches: State policy should include developing and promoting state-wide standards, meaningful recognition of

trauma programs, resources to implement those programs, and validation of results achieved through trauma-informed services .

Policy Recommendations:

- a) All juvenile mental health services should be trauma-informed, family and community-connected to the greatest extent possible, and whenever possible include family engagement, from the outset, in treatment planning and counseling;
- b) Evaluation and metrics are important. Data analysis should be done internally, and include client, program and global indicators of effectiveness. In juvenile justice outcome measures tend to focus on reducing re-offense, which is beneficial, yet it would be effective to also look at skill development in resiliency, as well as educational, emotional, social, family, peer and creative domains of well-being;
- c) There should be State-level incentives/resources for comprehensive behavioral health for youth and young adults, including screening, assessment, and treatment approaches keyed to social/family/school functioning. Tracking of long term positive indicators for individuals such as academic achievement, family stability, positive relationship development, overall health, will show cost savings for public systems, etc., and support requests for more resources.

Twitchell: San Diego Risk and Resiliency Checkup – similar to intake/assessment, the new version looks at change across domains including multi-factor variables, and tracks long term outcomes. TIC has changed the psychological model by asking ‘what has happened’ rather than just emphasizing symptom reduction, resulting in more meaningful, substantial, long lasting change.

Hornberger: Ventura and Santa Barbara counties are participating in the McArthur Foundation’s national Mental Health/Juvenile Justice Initiative “Models for Change”, part of the Mental Health and Juvenile Justice Collaborative for Change. The focus is on system reforms that include Evidence Based Practices, Trauma-Informed Care, Case management, family supports and workforce training supported by policy changes. There has been a drop in the Juvenile Justice population, but increased referrals to Law Enforcement for school discipline issues: the ‘school to prison pipeline’. Kids are coming to probation who haven’t committed a criminal offense. McArthur Foundation and the Council on State Governments are interested in what issues and policies in schools are responsible for this. She will send resource documents to LL to distribute to members.

Discussion: 2014 AB114 and Community Forum reports, and CSI Committee Work Plan 2015

LL has received some public comments on the AB 114 Transition report, and thinks that these may involve only minor modifications. A name change was suggested for this report so that it can be easily located in a search. The Community Forum report did not receive any comments. Both reports were approved by members as drafted. The report on Trauma-Informed Care was also distributed for review, but members thought it was too soon to evaluate and approve it. Committee members recommended adding Nancy

Hornberger's recommendations to this report. Review and approval will be moved to the agenda for the first In-between meeting/ conference call.

Public Comment - None

Evaluate Meeting/Develop Agenda for Next Meeting: Those present enjoyed the presentations and thought the format of the meeting was good. Next month's agenda will include in order of priority: the Data Notebook theme; the CSI Work Plan; and approval of the Trauma report. April's Quarterly meeting should include another presentation on mental health and juvenile justice in Los Angeles County. June's Quarterly meeting in the Bay Area will include a presentation on homelessness and mental illness.

Meeting was adjourned at 12:00.

Continuous System Improvement Committee
Meeting Highlights
Tuesday, February 24, 2015

Committee Members Present:

Susan Wilson, Chair
Lorraine Flores, Chair-Elect
Kathleen Casela
Raja Mitry
Monica Nepomuceno
Walter Shwe

Staff Present:

Laura Leonelli

Welcome and Introductions - The meeting was held by teleconference. Chair Susan Wilson called the meeting to order at 9:05 am, and requested that callers identify themselves when making comments. Those attending introduced themselves.

Discussion: Data Notebook Theme for 2015 - Questions for the 2015 Data Notebook should follow a theme or focus. A suggested focus was mental health in the juvenile justice system. There were a number of themes suggested by CMHPC members at the January Quarterly meeting, but the Executive Committee has not yet decided on an overall focus for the Planning Council. Another suggestion for a focus was the integration of Substance Use Disorders (SUD) with Behavioral Health care. Most counties (50/58) are combining SUD with BH and County SUD program directors have already merged with MH directors to form the County Behavioral Health Directors Assn. This topic would inform the direction of the Planning Council as it considers integration as well. Workforce issues are also important to consider – for development, recruitment, cross-training, etc. This theme would relate to the Juvenile Justice topic as well as the SUD/MH integration topic. Focus questions would assist counties to review what has already been done and what still needs to be done.

The Data Notebook document should be completed by June 2015, and data trainings will be held for Local Mental Health boards. The instruction format will build on last year's training and would not take long to organize.

What about a Data Notebook committee? The CSI members can decide the topic, within the parameters of the CMHPC overall theme, and then include others (eg CALMHB/C members) to refine the proposed questions, review the draft Notebook, and assist in the trainings.

Recommendation: the Data Notebook focus topic should be the integration of MH/SUD services in each county. Those attending agreed with this recommendation. Additional topics of children's services and mental health in the juvenile justice system were also suggested.

Discussion: CSI Work Plan goals and research topics – How to reflect the Planning Council's theme in the CSI Work Plan? Since the Data Notebook focus will be SUD/MH integration, the Committee agreed that the 2015 Work Plan will include a report on mental

health programs in the juvenile justice system, and another report on model programs for homeless mentally ill. Both of these populations have issues with substance abuse, so there is some overlap with SUD/MH integration. Another suggested topic, as a follow-up to last year's AB 114 report, is an assessment of school-based mental health services for general education students. The CMHPC is continuing to hold ethnic community forums, and these have also been reported to the CSI Committee. LL will prepare the work plan template to include goals, activities and outcomes for each topic.

Discuss for Approval: CSI Trauma-Informed Care report of 2014 – this report has been finalized but was sent only to the Co-chairs and not all the Committee members. LL will send out electronically and request approval by members through email. Susan Wilson requested that members be sent a link to a TED talk given by Nadine Burke Harris, CEO of the Center for Youth Wellness, on the effects of childhood trauma:

http://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime

Next Steps and Future Agenda Items: It was agreed that the April Quarterly meeting will have a presentation on mental health in the Los Angeles County juvenile justice system. The June Quarterly meeting will focus on homelessness and mental illness. Santa Clara County will report on model programs. Lorraine is already coordinating the presentation.

Public Comment: None

Adjourn: The meeting was adjourned at 9:50 am.

X INFORMATION

TAB SECTION B

_____ ACTION REQUIRED

DATE OF MEETING 4/16/15

MATERIAL
PREPARED BY: Leonelli

DATE MATERIAL
PREPARED 3/13/15

AGENDA ITEM:	Preliminary Data Notebook draft, proposed questions
ENCLOSURES:	
OTHER MATERIAL RELATED TO ITEM:	Draft Data Notebook 2015 with questions (handout)

ISSUE:

The Data Notebook is the primary work product from the Continuous System Improvement Committee. After the successful completion of the 2014 Data Notebook, the Planning Council is preparing to finalize the 2015 version with different questions. These have been developed to reflect the current research topics selected by the CSI Committee at the February meeting. After the Committee's review and approval, the Data Notebook will be reviewed by the entire Planning Council. The Data Notebook is expected to be distributed to County Mental Health Boards by June, 2015.

_____ **INFORMATION**

TAB SECTION C

 X **ACTION REQUIRED:** Approve
2014 Trauma Report

DATE OF MEETING 4/16/15

**MATERIAL
PREPARED BY:** Leonelli

**DATE MATERIAL
PREPARED** 3/10/15

AGENDA ITEM:	Update: New Community Forum Write-up, and Approval: revised 2014 Trauma report
ENCLOSURES:	<ul style="list-style-type: none">• Trauma-Informed Care report• Hmong Community Forum Write-up
OTHER MATERIAL RELATED TO ITEM:	

ISSUE:

- a) One of the work products of the 2014 Continuous System Improvement Committee Work Plan is the report on Trauma-Informed mental health care. The report needs to be reviewed and approved by the CSI Committee in order to be released by the CMHPC to state-wide stakeholders. The draft was sent to committee members after the last Quarterly meeting, and is included in this Meeting Packet.

- b) The Planning Council has decided to conduct Community Forums to fulfill the mandate in WIC 5772, h. ["To conduct public hearings on the state mental health plan, Substance Abuse and Mental Health Service Administration (SAMHSA) block grant, and other topics, as needed"]. The focus for Community Forums in 2015 is ethnic/cultural communities. The write-up of our Hmong forum on February 25 is included for Committee review.

Staff would appreciate your constructive comments on the report so they can more accurately represent the Committee's work.



Trauma-Informed Mental Health Care in California:
A Snapshot

December 2014

Prepared for: The Continuous System Improvement Committee of the California Mental Health Planning Council

By: Laura Leonelli, MA, Staff Analyst

Grateful acknowledgement and thanks for advice and help in developing this project goes to:

- Jane Adcock, Executive Officer, CMHPC
- Patricia Bennett, PhD, Chair, CSI Committee – CEO, Resource Development Associates
- Susan Morris Wilson, Chair-Elect, CSI Committee – Youth Violence Prevention Council
- Dante Dautz, JD, ACE Program Manager, United Pan-Asian Communities
- Dawn Griffin, PhD, Program Director, Department of Undergraduate Psychology, Alliant University
- Elizabeth Knight, MFT, San Diego County Behavioral Health Services, Trauma-Informed Guide Team
- Charles Wilson, Project Director, Chadwick Trauma-Informed Systems Project, Chadwick Center for Children and Families
- Steven Blum, Mental Health Clinical Specialist, Central (Contra Costa) County Adult Mental Health, *Libby Madelyn Collins Trauma Recovery Project*
- Cecilia Chen, Esq., Policy Analyst, Center for Youth Wellness
- Suzy Loftus, Esq., Chief Operating Officer, Center for Youth Wellness
- Kyndra Simmons, Program Manager, *Caught in the Crossfire*, Youth Alive

California Mental Health Planning Council

**Trauma-Informed Mental Health Care in California:
A Snapshot**

Introduction:

The California Mental Health Planning Council (CMHPC) is mandated by federal law (Public Law 106-310) and state statute (Welfare and Institutions Code (WIC) 5772) to advocate for children with serious emotional disturbances and adults and older adults with serious mental illness; to review and report on the public mental health system; and to advise the Administration and the Legislature on priority issues and participate in statewide planning. One of the priority issues that the CMHPC has been investigating is trauma-informed mental health care. The CMHPC has received briefings from statewide experts at its 2014 quarterly meetings in San Diego and in Oakland on programs to address the effects of early trauma on both children and adults. This report describes some leading programs that are being implemented in California, within the context of recent trauma-focused research and national recommendations for best practices in trauma-informed mental health care.

Trauma is a widespread, harmful, and costly public health problem. It occurs as a result of violence, abuse and maltreatment, neglect, loss, disaster, war, and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. Traumatic exposures may have only transient effects resulting in no apparent harm; however, traumatic exposures often result in psychological harm, increased rates of mental illness, suicide, risk-taking behaviors, and chronic physical disorders. Exposure to trauma may increase the likelihood of substance abuse and lead to disruptions in daily functioning in educational and employment settings. Trauma is an almost universally shared experience of people receiving treatment for mental illness and substance use disorders, including those served through public systems. ¹

The relationship between traumatic childhood experiences and physical and emotional health outcomes in adult life is at the core of the landmark Adverse Childhood Experiences (ACE) Study, a collaborative effort of the Center for Disease Control and Prevention and the Kaiser Health Plan's Department of Preventive Medicine in San Diego, CA. The ACE Study involved the cooperation of over 17,000 middle-aged (average age was 57), middle class Americans who agreed to help researchers study the following nine categories of childhood abuse and household dysfunction:

- recurrent physical abuse
- recurrent emotional abuse
- contact sexual abuse

¹ Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

- an alcohol and/or drug abuser in the household
- an incarcerated household member
- a household member who is chronically depressed, mentally ill, institutionalized, or suicidal
- mother is treated violently
- one or no parents
- emotional or physical neglect

The study claims two major findings. The first of these is that **ACEs are much more common than anticipated or recognized**, even in the middle class population that participated in the study. The study's second major finding is that **ACEs have a powerful correlation to health outcomes later in life**. As the ACE score increases, so does the risk of an array of social and health problems such as: social, emotional and cognitive impairment; adoption of health-risk behaviors; disease, disability and early death. Nearly 2/3 of ACE Study participants reported at least one ACE, and more than one in five reported three or more. The higher the ACE score, the greater the risk of heart disease, lung disease, liver disease, suicide, HIV and STDs, and other risks for the leading causes of death.²

Many mental health and substance abuse providers may be under the impression that abuse experiences are an additional problem for their clients, rather than the central problem. Post-Traumatic Stress Disorder (PTSD) is often the only diagnosis utilized to address abuse; in fact, every major diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) can be related to trauma.³

Trauma is especially prevalent among populations who have been involved with the child welfare and criminal/juvenile justice systems or who reside in communities with high rates of violence. Given the relatively high rates of exposure to traumatic events and the potential for long-term consequences when unrecognized and untreated, it is critical that public health systems screen for and intervene early with evidence-supported trauma interventions. Trauma-specific interventions have been developed for use across the life-span; however, because these interventions are transformational they should be implemented across entire systems. Since the application of a trauma-informed approach in states and counties has been limited, individual practitioners are often unaware of or may not use interventions based on the best evidence. With the increased recognition of the centrality of trauma in mental and substance use disorders, public systems should

² Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., Marks, J. S. (1998). *Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study*. *Am J Prev Med*, 14:245-258.

³ *The Damaging Consequences of Violence and Trauma: Facts, Discussion Points, and Recommendations for the Behavioral Health System* (Jennings, 2004). p. 5
<http://www.nasmhpd.org/docs/publications/archiveDocs/2004/Trauma%20Services%20doc%20FINAL-04.pdf>

embrace the need to create trauma-informed service delivery systems that support behavioral health consumers and survivors of trauma. A trauma-informed approach to care is based on consumer choice and decision-making, prohibition of coercive or forced treatment and promotion of safety and strengths-based practice.⁴

Without trauma-informed interventions, there can exist a self-perpetuating cycle involving PTSD and substance abuse, where trauma (childhood or adult physical and/or sexual abuse, crime victimization, disaster, combat exposure) leads to the development of PTSD symptoms, triggering the use of alcohol and drugs, resulting in higher likelihood of subsequent traumatic events and re-traumatization, leading to development of more chronic PTSD symptoms, triggering heightened substance use, and so on.⁵

Trauma screening involves brief evaluation of potential trauma symptoms and/or history. Such screening can indicate a potential need for further assessment and treatment. Trauma screening instruments can be administered quickly by a range of professionals and can be conducted independently or as part of a broader screening and/or assessment process.⁶ Mandatory trauma assessment should be available for all children referred for behavior, learning, or emotional disturbances, followed by referral to appropriate trauma treatment. Without medical and mental health screening that is trauma-informed, both children and adults can be misdiagnosed and will neither receive appropriate treatment for the underlying causes of their illness nor achieve a meaningful recovery.

Timely preventive screening and treatment for trauma-related mental illness provides cost savings as well as the opportunity for wellness and recovery. Beginning in January 2014 under the Affordable Care Act (ACA), all new small group and individual market health insurance plans are required to cover ten Essential Health Benefit categories, including mental health and substance use disorder services, and will be required to cover them at parity with medical and surgical benefits. Because of the law, most health plans must now cover preventive services, like depression screening for adults and behavioral assessments for children, at no additional cost. Serious mental illness costs billions in lost earnings per year and is a leading cause of disability in the U.S. Before the expanded coverage provided by the ACA, millions of emergency department visits were made by adults for mental health conditions; over one in eight were uninsured. Disproportionate numbers of youth and adults with mental illness are in jails and juvenile facilities, often as a result of untreated mental illness linked to trauma.⁷

SAMHSA Trauma Approach Guidance, July 2014

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has chosen Trauma and Justice as one of its Strategic Initiatives (Leading Change 2.0:

⁴ Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

⁵ *The Damaging Consequences of Violence and Trauma: Facts, Discussion Points, and Recommendations for the Behavioral Health System* (Jennings, 2004). p. 6

⁶ U.S. Department of Health and Human Services: *Letter on Children and Trauma*, July 11, 2014

⁷ National Alliance on Mental Illness: [ACA Fact Sheet #9 Mental Health and the Uninsured](#)

Advancing the Behavioral Health of the Nation 2015-2018). Over the past 20 years, SAMHSA has promoted a trauma-informed approach to behavioral health care that shifts away from the perspective of “What’s wrong with this person?” to a more holistic view of “What happened to this person?” This becomes the foundation on which to begin a healing and recovery process, and the approach has become more widely adopted by state and local programs in the past several years. SAMHSA has supported this approach through technical assistance resources such as the National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint, the National Child Traumatic Stress Network, and the Children’s Mental Health Initiative; as well as the Women, Children and Family Substance Abuse Treatment Program, the Offender Reentry and Adult Treatment Drug Court Programs and the Jail Diversion Trauma Recovery grant program.

The SAMHSA Guidance for a Trauma-Informed Approach does not outline prescribed practices or procedures, but instead recommends 6 over-arching principles. These are:

1. Safety – both in the physical space and psychologically, in all interactions
2. Trustworthiness and Transparency – at both interpersonal treatment and organizational levels
3. Peer Support – individuals with lived experience of trauma can provide the most effective services by establishing trust and safety
4. Collaboration and Mutuality – sharing power and decision making, at both personal and organizational levels
5. Empowerment, Voice and Choice – clients are supported in shared decision making, choice of interventions and goal setting for their own healing and recovery
6. Cultural, Historical and Gender Issues – organizations and practitioners move past cultural biases and incorporate policies and protocols that are responsive to the racial, ethnic and cultural needs of individuals served⁸

Model Trauma-Informed and Trauma-Specific Programs in San Diego and Bay Area

A program, organization, or system that is trauma-informed follows SAMHSA’s four “Rs”:

- **Realizes** the widespread impact of trauma and understands potential paths for recovery
- **Recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system
- **Responds** by fully integrating knowledge about trauma into policies, procedures, and practices
- Actively seeks to **resist re-traumatization**⁹

In January 2014 at its Quarterly Meeting in San Diego, the CMHPC heard presentations by local trauma-informed care experts. The **San Diego County Department of Behavioral Health (DBH)** reported that in 2012 they contracted with Dr. Dawn Griffin of Alliant University, who conducted a Trauma-Informed Assessment which resulted in nine

⁸ Substance Abuse and Mental Health Services Administration. *SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

⁹ Ibid.

recommendations for system improvement. For example, Dr. Griffin emphasized that understanding how cultural context influences one's perception of and response to traumatic events and the recovery process allows service providers to use interventions respectful of and specific to cultural backgrounds. She recommends that cultural competence measures include trauma awareness.

San Diego County has established a Trauma-Informed Guide Team (TIGT) of mental health specialists who have received training on the effects of trauma. The TIGT has developed core competencies that include: **Engaging leadership at the top; Making trauma recovery consumer-driven; Emphasizing early screening; Developing a trauma-competent workforce; Instituting standard practice guidelines; and Avoiding recurrence or re-traumatization.** The TIGT trains agencies and systems such as first responders (ambulance drivers, firefighters) and educators at the San Diego Community College District and San Diego Unified School District in these core competencies to involve communities as well as mental health professionals. The issue has attracted enough public support that the City of San Diego has declared a Trauma-Informed Day, in conjunction with the National PTSD Awareness Day June 27, 2014.

The **Union of Pan-Asian Communities** (UPAC) of San Diego County Adverse Childhood Experiences Program is supported through Mental Health Services Act (MHSA) Prevention and Early Intervention funds. The program is a comprehensive collaboration of four social service agencies whose activities are designed to prevent community violence and gang activity. There are two types of services: direct services to youth and a mobile response team which goes to the site of homicides and provides trauma-informed intervention. Collaborative partners give people involved in traumatic incidents the support and resources they need. If people are so traumatized that they don't want to talk about it at the time, the program staff will contact them later. Clients are also encouraged to write about their traumatic experiences. Grief recovery support is provided for all kinds of loss: not only through death but through Child Welfare, incarceration, etc. Grief support is conducted through workshops or home visits. Program staff are often former gang members or former mental health services consumers. Because the staff work with very traumatic experiences, there is a large potential for vicarious traumatization, especially since they live in, or are familiar with, the community they serve. Staff burnout is always a factor. The team supports each other through regular empathic de-briefings.

Mr. Charles Wilson of the **Chadwick Trauma-Informed Systems Project, Chadwick Center for Children and Families** at Rady Children's Hospital San Diego explained that trauma and traumatic stress are the interaction between the distressing event, the perception by the individual, and the lasting impact on that individual. Child traumatic stress is the physical and emotional reaction to events in a child's life that threatens their life or physical integrity, or that of someone close to them. It overwhelms the child's capacity to cope. It causes physiological reactions and changes the biology of the child. Trauma reminders are frequent and can trigger post-traumatic stress. Rady Children's Hospital is a member of the National Child Traumatic Stress Network. The Chadwick Center for Children and Families trains professionals across disciplines for collaboration in trauma-informed service delivery. The training emphasizes that assessment and screening

for trauma exposure in children by all collaborative partners is needed for services to be effective. Treatment provided by all partners should teach children how to build resilience. Enhancing family well-being is essential in effective treatment of children. Families need to be active partners in treatment and they have much wisdom to contribute to the process.

Mr. Wilson and Dr. Griffin discussed how some people's serious and profound mental illness may have origins in trauma while others may have origins purely in biology. Some who have serious mental illnesses through biology are at a greater risk of trauma. Sometimes the exacerbating condition is not trauma but rather toxic stress.

Researchers believe that toxic stress is the link between trauma and poor health. Stress activates the body's 'fight or flight' response, a normal reaction to fear. Toxic stress results from ongoing exposure to trauma, where the body's stress reaction is activated over and over again. This issue is the subject of the white paper "An Unhealthy Dose of Stress",¹⁰ published by the **Center for Youth Wellness (CYW)** in San Francisco. Suzy Loftus, Chief Operating Officer of the organization and Cecilia Chen, Policy Analyst, presented to the CMHPC's Quarterly meeting in Oakland in June, 2014. The CYW is working to expand the audience to improve holistic health responses for children. At present, the medical field has not fully embraced the ACEs study and the impact of traumatic experience on the developing brain and body. (However, ACEs have been measured since 2008 as part of a statewide health survey conducted by the California Department of Public Health.) The Center's research indicates that behavior difficulty is an indicator of other serious issues that can lead to chronic diseases, mental illness, and substance abuse. The CEO and founder is Dr. Nadine Burke Harris, a pediatrician who is committed to addressing health disparities in San Francisco's Bayview- Hunter's Point district. Based on a needs assessment of her patients and their families, Dr. Harris worked with Sutter/CA Pacific Medical Center to open a clinic. The clinical model includes universal trauma screening for children ages 0 -18 and their parents, using non-specific ACEs, to identify chronic adversity as a health risk. Pediatricians and therapists work together at the Center and they hold joint multidisciplinary rounds and case conferences. Wellness nurses educate families on trauma and stress. The Center offers Dr. Alice Lieberman's child/parent psychotherapy model, nutrition therapy, biofeedback and other clinical interventions.

Caught in the Crossfire, a violence intervention and prevention program of Youth Alive, based in Oakland, also presented at the CMHPC meeting in June 2014. It is part of a national network of 25 hospital-based violence intervention programs. They serve patients aged 12 – 24 years at Oakland Children's Hospital, Highlands Hospital, and Eden Medical Center in Castro Valley. They hire people who have had similar experiences and backgrounds as the clients but who are now older and have been through recovery. The staff receive professional training that builds both relational and program management skills. It's called a peer-based model, and youth accept and relate better to staff who have lived experience. Intervention Specialists reach out to the family at a victim's bedside after a violent incident. After release from the hospital they provide long term case management including housing assistance and employment services if needed. Both victims and families

¹⁰ ["An Unhealthy Dose of Stress"](#) Center for Youth Wellness, White Paper on Toxic Stress (June 2013)

can receive therapy, and services are provided at the home. If client families move, they can be connected with program partners at other locations in the national network.

Both of the expert panels indicated that programs and resources for youth are becoming more trauma-informed as awareness grows about the social, mental and physical impacts on child development. In contrast, it is rare to find trauma-informed programs for adults and/or older adults that are not focused on domestic violence survivors. The CMHPC heard from one program for adults being implemented in Contra Costa County through MHSAs funding: the **Libby Madelyn Collins Trauma Recovery Project**. It was developed from the observation that about 90% of 5150s are not related to a primary mental health diagnosis, but are frequently due to trauma-related responses to trigger incidents. Usually trauma histories for adults are unknown to therapists. Mr. Steven Blum, Mental Health Clinical Specialist, found there was no other program in the area that addresses adult trauma in Axis I or II diagnoses. He developed a group model based on an adapted individual model.¹¹ Weekly group sessions are held at county mental health clinics, a LGBT community center, and a MHSAs wellness center. Group participants are men and women, aged 18 – 60+ years, with unexplored past trauma. In the groups people do not share details of their trauma, but they learn to handle triggers for trauma through cognitive restructuring. The model, based on Dr. Kim Mueser's work, involves identifying feelings, thoughts associated with the feeling, and validation of those thoughts. The person him- or herself decides if a thought is accurate after feedback from the group. Then the participants develop an action plan to deal with their issue.

Best Practices employed by the model programs surveyed by the CMHPC include:

- Universal screening of patients, clients and group participants for trauma history
- Peer-based services and programs that employ trauma survivors
- Awareness of the effects of trauma across systems of care and inter-agency collaboration in service delivery
- Localized services that are provided where clients can access them most easily

State Initiatives regarding Trauma

Earlier this year (2014) Assembly Continuing Resolution (ACR) 155 was sponsored by both Youth Alive and the Center for Youth Wellness, among other organizations. ACR 155 encourages statewide policies to reduce children's exposure to adverse childhood experiences and stress. Authored by Assemblymember Raul Bocanegra (D-39), ACR 155 unanimously passed the state Assembly on August 11, 2014 adding 67 members as coauthors. The resolution was introduced for a vote on August 18 in the state Senate by Senator Holly Mitchell (D-Los Angeles). The resolution passed the state Senate 34-0. This makes California only the second state in the country to pass a resolution recognizing the

¹¹ Mueser, K. T., Rosenberg, S. D., & Rosenberg, H. J. (2009). Treatment of Posttraumatic Stress Disorder in Special Populations: A Cognitive Restructuring Program. Washington, DC: American Psychological Association

impacts of ACEs and toxic stress on childhood development.¹² The CMHPC was one of many organizations statewide that provided a letter of support.

Trauma-informed approaches are central to the Positive Youth Justice Initiative (PYJI) sponsored by the Sierra Health Foundation with additional funding from The California Endowment and The California Wellness Foundation. The program launched in 2012 with pilot projects in 6 counties throughout the state. PYJI focuses on *crossover youth* — young people with histories of neglect, abuse and trauma who currently are involved with their juvenile justice systems. Probation Departments in Alameda County, San Diego County and San Joaquin County, as well as the Vallejo City Unified School District in Solano County received implementation grants to test a series of reforms designed to transform juvenile justice into a more just, effective system and improve the lives of the youth they engage.

At the CMHPC Quarterly meeting in January, 2015, these recommendations were made by one of the presenters, Nancy Gannon Hornberger, CEO of Social Advocates for Youth, San Diego:

What can collectively be done to promote trauma-informed approaches: State policy should include developing and promoting state-wide standards, meaningful recognition of trauma programs, resources to implement those programs, and validation of results achieved through trauma-informed services.

Policy Recommendations:

- a) All juvenile mental health services should be trauma-informed, family and community-connected to the greatest extent possible, and whenever possible include family engagement, from the outset, in treatment planning and counseling;
- b) Evaluation and metrics are important. Data analysis should be done internally, and include client, program and global indicators of effectiveness. In juvenile justice outcome measures tend to focus on reducing re-offense, which is beneficial, yet it would be effective to also look at skill development in resiliency, as well as educational, emotional, social, family, peer and creative domains of well-being;
- c) There should be State-level incentives/resources for comprehensive behavioral health for youth and young adults, including screening, assessment, and treatment approaches keyed to social/family/school functioning. Tracking of long term positive indicators for individuals such as academic achievement, family stability, positive relationship development, overall health, will show cost savings for public systems, etc., and support requests for more resources.

In Conclusion:

Recent regional conferences on Trauma demonstrate the increasing awareness and growing acceptance of best practices for trauma-informed mental health treatment. These include several 2014 events sponsored by the San Francisco Mental Health Education Funds at the California Endowment office in Oakland, and the “Children Can Thrive: California's Response to Adverse Childhood Experiences” conference sponsored by the

¹² Chen, C. *California becomes only second state in country to pass resolution on ACES, toxic stress.* http://www.centerforyouthwellness.org/blog/ACR155_3

Center for Youth Wellness on December 3, 2014 which was the first-ever statewide summit on adverse childhood experiences (ACEs). On Feb. 8, 2013 Placer County hosted 17 other Northern California counties in a day-long symposium focused on possible development of a regional approach for treating victims of early, severe trauma which may include working with private-sector partners to create a regional treatment center for young trauma victims.

While not intended to be a comprehensive list, the trauma-informed programs, conferences and initiatives referenced reflect a trend towards transformation of mental health and related systems throughout California. The Mental Health Services Act, through its Prevention and Early Intervention and Innovation components, provides local support for collaborative trauma-informed approaches in many counties across the state.

The following articles highlight the programs mentioned:

Google gives \$3 million to Nadine Burke Harris' Bayview clinic: <http://www.sfgate.com/bayarea/article/Google-gives-3-million-to-Nadine-Burke-Harris-5865372.php?cmpid=email-desktop>

Gilligan, H.T. "Study: Millions of Californians have Higher Risk of Disease Following Childhood Adversity": <http://www.healthycal.org/study-millions-of-californians-have-higher-risk-of-disease-following-childhood-adversity/>

Graebner, L. "Hospital-based Programs Break Cycle of Violent Injury": <http://www.healthycal.org/hospital-based-programs-break-cycle-violent-injury/>

California Mental Health Planning Council (CMHPC)
“We’re Listening” Forum on Mental Health in the Hmong Community
February 25, 2015
Fresno Center for New Americans

This community forum was planned for the Fresno area which is home to one of the largest populations of Hmong immigrants in the state. Hosting and facility were provided by staff of Fresno Center for New Americans (FCNA), the largest Hmong community-based organization in Fresno County. FCNA is implementing three culturally based mental health programs through Mental Health Services Act funding: the Living Well Program, the Horticultural Therapeutic Community Centers (HTCC), and the Holistic Cultural Education and Wellness Center.

Attendance included 43 community members (40 Hmong, 3 Lao), 2 members of the Fresno County Behavioral Health Board, 2 graduate psychology students, 5 staff of the A/PI program at Fresno County Behavioral Health department, and FCNA program staff. Also present were one CMHPC member and 2 staff, and a professional interpreter.

CMHPC has developed a set of guiding questions that will provide a framework for discussion at this and future ethnic community forums.

Stakeholder Comments

Guiding Questions:

- 1. What is the biggest barrier that keeps people you know from coming in for mental health services** – for example, men? The facilitator noted that all the community members present were female, most over 50 years old. Why don't men seek or participate in mental health services? Responses included that “men are not depressed like women are”, men don't feel comfortable sharing their feelings, and men won't participate in groups where there are mostly women participants. A Hmong therapist stated that mental health stigma is still a bigger issue with Hmong men than women. They have trust issues with trying out new ways of helping. Hmong women are more open to this than Hmong men. The culture of the Hmong men is not as open to seeking out help and talking to others about their own problems. [Both Fresno County BH and FCNA currently offer counseling groups for men.]

Youth? Participants responded that young people really don't know about available mental health services for them. More outreach and education is needed to raise awareness of youth mental health issues, for both youth and their families. Advocacy is needed to create more services for youth. When asked about mental health services in schools, one student responded that she was aware of grief counseling groups, but not other services. There was some discussion of the importance of preventive mental health services for youth: more Hmong teens committed suicide in Fresno County in the late 1990's- early 2000's than in any other area.

- 2. For people you know who receive mental health services, anywhere, are the services meeting their needs?**

An informal poll of the participants revealed that the vast majority were receiving services at FCNA. The discussion centered around their favorite program, the Community Gardens. When asked why this program is effective for them, they responded that gardening provides a familiar activity that they know and have practiced all their lives. It reminds them of their former life in Laos. It is good exercise and physical activity, and helps to take their mind off their health concerns and family problems. Community gardens provide a means of connecting and socializing with other program participants. The women love to see the vegetables and herbs that are the results of their hard work. Gardening makes them feel productive, independent and useful. If anything, they feel that the program should be bigger and provide more space and water for more people to participate.

Several women related their own life story, but their experiences are not unique. Women in their older age experienced trauma 40 years ago when their country was at war. They lost relatives, their homes, everything that was familiar. They experienced different trauma as they tried to adjust to the completely new world that they found in the U.S. They were uneducated, they felt inadequate, they were homesick and they had lost control over their life. Their marriages suffered, some were abandoned either physically or emotionally by their husbands. Their children acculturated to a social system that values youth and disrespects old age. Many women said they have lost the ability to communicate with their children and in any case the children don't listen to them. They are isolated in their homes, they can't drive to errands and appointments, and their income is very limited. These older women reported that they suffer major depression, with suicidal ideation. For them, therapy is having someone listen to them and the opportunity of activities that provide a brief respite from their daily cares and problems.

Fresno County Behavioral Health reported that there are a total of 7 community garden projects that include one for Russian-speakers and one for Punjabi residents.

Hmong clinicians who attended this forum state that there are no other culturally and linguistically appropriate mental health services besides Fresno County Behavior Health Department's Asian/ Pacific Islander (API) Program and Fresno Center for New Americans' Living Well Program. The limited culturally and linguistically appropriate mental health services and locations are inadequate to meeting the mental health needs of the second largest Hmong population in the country.

For those currently receiving mental health services outside of FCNA and the County A/PI Program, due to the shortage of Hmong mental health clinicians and providers (MDs), the concern is that they are receiving inappropriate and inadequate mental health care. For example, where the counselor or clinician is not a Hmong person, an untrained Hmong interpreter may be used.

- 3. How do you know when services are really helping people? What results are we looking for?** How do you know that the services are helping you to feel better?

- Before we felt sick, sad, crying often, even felt like committing suicide. Now we feel healthy, feel happier, and have more activities and interests in life.
- We know that it is helpful to have people who listen to us and offer advice about how to solve our problems.
- We didn't know any services were available to help us, and now we can receive many services from FCNA and we have more hope for our life here in the U.S.
- Clinicians report that changes in a consumer's thinking, behavior, emotional control, personal appearance and consistent attendance to their mental health appointments reflect the positive outcomes of mental health treatment

4. Are there any services that are not available that you think would help people with mental health needs?

- Several people mentioned that more and better transportation is needed. Without reliable and consistent transportation to and from their appointments, many clients' treatment are consistently being interrupted and delayed. This is having a tremendous impact on clients' overall treatment outcomes. [Lack of transportation is a reported problem across urban and rural areas in every county.]
- Outings to local destinations to get to know the surrounding area. People mentioned that they've never traveled much outside their neighborhoods. [Fresno County BH has a program that provides weekly outings for people who meet the eligibility criteria for specialty mental health services.]
- Exercise programs, perhaps with equipment and an instructor. Many people with mental illness also suffer from chronic diseases like diabetes and hypertension, and they recognize that they need more physical activity. Walking or jogging in some neighborhoods is dangerous, and people don't go out at night.
- More one-on-one counseling, there are not enough providers for this service.
- 24-hour access to mental health services (in case of crisis or emergency)
- Youth services, such as a recreation center where teens can also access mental health education and services
- Educational shows on mental health issues in Hmong media (both TV and radio)
- A holistic focus that includes mental, spiritual and physical wellness. Inclusion of the entire family in services, and an emphasis on healthy relationships.
- Arts and crafts activities
- Multiple services available at one location

5. What is the best way to engage your community to discuss and plan mental health services?

This question either was not fully understood, or not very well explained. The participants spoke about other subjects and didn't address the meaning of the question. Per the Hmong interpreter: The women are FCNA clients and limited in their views, being older and first generation refugees with tribal backgrounds from the hills of Laos. They are rarely solicited for their opinions nor have they any experience engaging in planning for what they need in the future. Technically they have very little to no comprehension of what mental health is all about. Participants

refer to FCNA (in Hmong) as “the house for brain damage and crazy people” when they talk among themselves. Generally, receiving therapy services is viewed in a negative connotation as one being “crazy” and it is highly stigmatizing to participate in therapy sessions. Traditionally, people go to clan leaders for problem resolution, although this is not the only observed practice nowadays. How the participants feel is relevant, but knowing what kind of needs and services are available is beyond their comprehension. Inclusion of others (non-mental health recipients) would generate more meaningful and substantive discussion. “Others” include family members, providers, and clan leaders for their perspective on problems. Identifying best practices to address those issues from the broader spectrum of wellness, recovery and resilience strategies would generate meaningful information worthwhile to know and use. [Note: FCNA operates a program called Equal Voice which “captures the voices and opinions of the Hmong community about their participation with private and public organizations, events and issues throughout Fresno”, via surveys and focus groups.]

_____ **INFORMATION**

TAB SECTION D

___X___ **ACTION REQUIRED: Approval
of Work Plan**

DATE OF MEETING 4/16/15

**MATERIAL
PREPARED BY: Leonelli**

**DATE MATERIAL
PREPARED 3/10/15**

AGENDA ITEM:	CSI Committee Work Plan 2015
ENCLOSURES:	Draft Work Plan
OTHER MATERIAL RELATED TO ITEM:	

ISSUE:

The CSI Committee started a discussion about goals for 2015 at the October Quarterly meeting. The final work plan was not completed, and this meeting will provide an opportunity to decide on goals for research and action in the coming year. Several topics were suggested at the January Quarterly meeting. This summary of Work Plan goals and activities should be reviewed and modified as necessary, and Committee members can approve the Work Plan in concept.

Continuous System Improvement Committee
2015 Draft Work Plan

Goal #1: Complete Data Notebook		Target Audience	
<i>WIC 5772 ...In conjunction with other statewide and local mental health organizations assist in the coordination of training and information to local mental health boards as needed to ensure that they can effectively carry out their duties...</i>		Local Mental Health Boards Mental Health Stakeholders	
Objectives	Action Steps	Timeline	Leads
<ul style="list-style-type: none"> Fulfill obligation of WIC 5772 	<ul style="list-style-type: none"> Gather information to design Notebook (Data Sources) Receiving Input Conduct Training for Mental Health Board members Compiling/Analyzing Input Drafting Statewide Report Draft Report complete; CMHPC approval; final edits; disseminate to stakeholders 	<ul style="list-style-type: none"> April 2015: Staff will present draft outline of Data Notebook to CSI Committee for review and approval Send to Stakeholders for input June 2015: Basic design of Data Notebook complete Trainings during/after June Quarterly Meeting October 2015: Receive completed county reports December 2015: First draft for CSI review and approval January 2016: Final draft 	<p>Linda Dickerson Susan Wilson</p>

Goal #2		Target Audience	
Identify best practices and make recommendations for mental health treatment in Juvenile Justice facilities.		Stakeholders: County Behavioral Health agencies, families, Probation Departments, advocates	
Objectives	Action Steps	Timeline	Leads
Gather Information on model programs and best practices	<ul style="list-style-type: none"> Organize presentations by County and private agencies implementing prevention and intervention programs for juveniles in 2 – 3 areas or regions 	January 2015 – April 2015	Lorraine Flores Susan Wilson
Identify Best Practices	<ul style="list-style-type: none"> Research recent studies on juvenile mental health issues, including trauma informed programs Presentation to Full Council 	Quarterly Meeting TBD	CSI Staff
Issue Recommendations	<ul style="list-style-type: none"> Draft report for CSI Committee review Include stakeholder review Draft Report complete; CMHPC approval; final edits; disseminate to stakeholders 	<p>October 2015</p> <p>January 2016</p>	

Goal #3		Target Audience	
Identify best practices and make recommendations for mental health programs for homeless adults and youth		County Behavioral Health agencies, Department of Health Care Services: Mental Health Services Division Governor, Legislature	
Objectives	Action Steps	Timeline	Leads
<ul style="list-style-type: none"> • Issue recommendations to Governor, County Behavioral Health Departments and DHCS <ul style="list-style-type: none"> ➤ <i>Are homeless persons receiving the services they need?</i> ➤ <i>What changes can be made to make services more effective?</i> 	<ul style="list-style-type: none"> • Presentations by model programs for homeless mentally ill • Research best practice, programs implemented in other areas • Presentation to Full Council? • Draft report for CSI Committee review, solicit input from stakeholders • Draft Report complete; CMHPC approval; final edits; disseminate to stakeholders 	<p>June 2015</p> <p>May – August 2015</p> <p>Quarterly Meeting TBD</p> <p>October 2015</p> <p>January 2016</p>	<p>Lorraine Flores</p> <p>CSI Committee Staff</p>

Goal #4		Target Audience	
To fulfill the CMHPC mandate of WIC 5772: <i>WIC 5772 To review and approve the performance outcome measures.</i>		MHSA Oversight and Accountability Commission CA Mental Health Planning Council members County Behavioral Health agencies MH Boards/Commissions MH Stakeholders statewide	
Objectives	Action Steps	Timeline	Leads
Research	<ul style="list-style-type: none"> Committee members to become well versed on Performance Indicators through presentations at Quarterly meetings Participation in Joint (OAC/CMHPC) Task Force on Performance Indicators Develop updated Performance Indicators and report to Stakeholders 	January 2015	Renay Bradley Linda Dickerson
Provide feedback		Ongoing 2015	
Adoption of CMHPC recommendations for updates		Quarterly Meeting TBD	
		Fall/Winter 2015 - 16	

Goal #5		Measure of Success	Target Audience	
Objectives	Action Steps	Data/Evaluation	Timeline	Leads