County of Los Angeles—Department of Mental Health
System Leadership Team Meeting
Meeting Notes for May 20, 2015

Reasons for Meeting

1. Discuss Consolidation Motion Proposed by the County of Los Angeles Board of Supervisors.
2. Provide an Update on the Department of Mental Health.
3. Give an Update on State Legislative and Budget Items.
4. Share Updates on MHSA-Related Items.

Meeting Notes

Item 1: Board Consolidation Motion Discussion	**Opening Remarks: Dr. Marvin J. Southard, Director, Department of Mental Health** Engaging community input about the best way of integrating services for clients is the right conversation to have. In the end, I think everybody is looking for ways that we provide the best possible care to the most people. So I think I that that is the overarching theme everybody in the room shares. **Board Consolidation Motion: Dr. Mitch Katz, Director, Department of Health Services** Good morning, thanks for inviting me, and thanks for all you do to make sure that the MHSA money is well spent. You have given me a set of questions and so I thought that I would talk about those questions rather than try to talk about the agency, which I think I can talk about as part of the questions. I would like to talk a little bit about myself and, maybe in the time that we have left, to hear a little bit more about you to understand our different perspectives. I grew up with two developmentally disabled siblings, which made a huge impact on me. I saw some of the great work what NAMI has done and what parents and families can do, because due to the Association for Retarded Adults in New York, which was a family run organization, my brother has lived most of his life in supportive housing—which is different than my aunt who died in an institution in an age when supportive housing never existed. I grew up knowing that I was gay at a time when that made me a deviant, a pervert. I did not know anybody who was gay. I was incredibly ashamed and embarrassed of how I felt and anything that I read about it from the professional world, whether it was physical doctors or mental health people, was bad. Fortunately, we do not live in that era anymore. I watched my father run around the house with blood dripping from his wrists when I was 15 years old. I totally did not understand what that meant or what exactly was going on. My mother was chasing him trying to get the razor out of his hand. Like many people who have chronic mental health problems, my dad has also had times of tremendous function, somebody for whom work was the best treatment. He has taken medications all of his life but I would not say that it was not the medication that made him function. I think the medication helped him; but, like my experience in general, medication often helps people but I do not think that it ever fundamentally changes things. It certainly has not changed this for my dad, who has been hospitalized many times throughout his life; but again has had periods of tremendous function, which go along with the themes of resiliency and recovery.

When I was in medical school, I started the first medical student group for gay and lesbian, bisexual medical students with a lesbian friend of a mine. We were not far enough in our own evolution to add transgender. Today a group like that would add transgender. But I remember what it was like back then, when I could not get many of the other students, who I knew to be gay and lesbian, to come because they were very afraid that they would be seen. And doctors back then were not gay, I still remember. I am 55, to give you some sense of the years we are talking about. I considered being a pediatrician and one of things that was against me was that if I came out and people knew that I was gay, people were not going to let me take care of their kids. We had tremendous trouble getting people to come to the meetings because they just did not want to be seen even though they knew they were gay.

I ran the AIDS office in San Francisco during the darkest years of the epidemic. That is really where I learned about how powerful groups like yours can be. Not only the gay community but also advocates for drug users, women, and children came together to say, 'There may not be a treatment that is available for HIV/AIDS but that does not mean we cannot do things.' And there were tremendous things to do just to block stigma. Again, people are fortunate to live in this era because I remember a patient of mine saying that she was concerned about seeing me because she knew that I had patients with HIV/AIDS. So strong were the feelings people had about people with HIV/AIDS.

I am probably one of the few people who have ever been screamed at by two ACT UPs at the same time from opposite ends on an issue. ACT UP is in some ways the original client/patient/consumer advocacy group. ACT UP was really a client group. They were not interested in service providers. They were interested in the clients. It was about clients taking back power.

In this particular meeting, I was promoting the first policies in San Francisco around giving post-exposure prophylaxis (PEP). That is where you give medications to people after they have been potentially exposed to HIV to try to decrease their infection. One ACT UP person was angry and screaming at me because the original rule said that we would provide it three times. But if someone kept getting exposed, we would take them through something different if we felt the PEP was not working. So they were screaming at me, 'Three times and you are dead!' And then the other ACT UP person was screaming at me that I was a pawn of the drug companies and that I was promoting the use of these toxic medications that were going to kill people all on the basis of trying to do this exposure.

So I do very much understand and believe in the power of groups to make a difference and the importance of involving the affected communities. I think that makes a huge difference.

The other thing that came forth very strongly through the HIV/AIDS movement was the importance of integrated services, especially because in the early years there was no medical treatment that was effective; so it was about housing, substance treatment, bringing people food, home nursing and mental health and finding places that people could get respectful and dignified care at the end of their life. Medicine was one of the 13 services that we provided under the Ryan White Care Act.

So I do very much believe in the idea of integrated care and that was the mantra of the program; and in particular, which relates to one of the reasons that I believe in the agency, the idea was to provide integrated care, not that you go here and then you go there and then you go there; not that this person gives you a phone number for that, but that you actually provide integrated care. All of my professional life, I have seen patients in public hospitals, San Francisco General Hospital, in the time that I was there.

Since I have come to Los Angeles, I see patients every week in the Roybal Clinic. I very much understand the cultural differences that separate or sometimes conjoin people. I'm a Spanish speaking provider and Roybal is the first clinic where Spanish is the dominant language. I love that about the Roybal Clinic: it is a Spanish dominant clinic, that is to say, almost everyone speaks Spanish, patients and staff. This is the first time that it has ever happened to me because, as a Spanish speaker, I have been typically in clinics where everybody speaks English and I get all of the Spanish-speaking patients. It has been wonderful to be in a clinic where in fact most of the business is done in Spanish. Occasionally I slightly insult somebody because I go into the room and I say, 'Buenas tardes. ¿En qué puedo servirle?' And the person replies, 'Hi.' I forget that people, of course, do sort of feel how the rest of the world feels when you speak English and they do not understand a word.

I think this is important and I think it is one of the misunderstandings that I feel, at least I see in some of the feedback I have received, the assumption that in medical practice that the seriously mentally ill are in the specialty system of mental health and that in the physical health system are the people with mild and moderate mental illness. Besides working at the Roybal Clinic, I see inpatients at LAC-USC and at Harbor Medical Center, where I have worked on the inpatient psychiatric unit as medical doctor.

I think that in terms of gross generalizations by percentage, that is true. But any public hospital and public clinic doctor will tell you, and this actually came up from Dr. Dowling who is a family practitioner at the Public Health Commission meeting, general primary care doctors all the time see people with serious mental illness who do not define themselves has having serious mental illness and who wish not to open up mental health cases. They do not see that as their problem, whether it is an issue of stigma or whether it is an issue of how they conceptualize that problem.

I think that this is one of the big potential gains. I think there is a misunderstanding that all of the people with the serious mental illnesses are in the specialty system. That is not true. The challenge for us as a community is you are about making sure that people with serious mental illness and moderate mental illness get the treatment they need. At least that is how I view it. It is not about what system is it; it is about that whatever system they are in they get the treatment they need.

That has certainly been a lot of the motivation behind the housing programs. Department of Health Services developed 600 units of housing last year in Los Angeles, something I was told would be impossible in here. Many of the people we house have a serious mental illness but do not wish to open up a case in mental health. I think that we as a community need to support them. We should encourage them, and we do, to seek out mental health treatment and many of them will after they have been housed. But the idea of either requiring that people first do that, I think that results in a large number of people not getting care.

So, sort of winding up, what I most notice—and I have now been here four and a half years running the Department of Health Services and I intend to spend the rest of my working life here—what I have noticed and learned is a little bit of the first question. I think that in terms of mental health treatment, I think Los Angeles does a wonderful job in the recovery model and taking care of people in the community and doing much more than just giving people medicines, much more than seeing people and visits but really doing a lot of empowerment work, work around employment, wellness, exercise, spirituality, in addition to medication.

But what I also notice, and what I would challenge us to do better on, is long before I came to Los Angeles I had heard that the largest mental

health facility in Los Angeles was the County Jail. I do not know why we find that acceptable. It has been that way for a long time. I am not the only one to make that observation and that is not new. Same thing if you bicycle or walk through Skid Row. What is that about? Why do we accept that? Is that really living in the richest country, one of the richest cities, and certainly the richest time of history? Is that really the best we can do? We just accept that? There are these blocks with rows of wheel chairs. That is just OK? We cannot do anything?

I authorized a needle exchange program in San Francisco at a time when it was illegal, when I was told that if I signed the order I would be arrested, and the mayor was told the same thing. Part of why that was such an event is I just do not necessarily agree that things are impossible. I do not agree that everything requires more resources to do it. More resources are always great, but right at this table we have $7 billion in resources. DHS is $4 billion, DMH is $2 billion, and DPH is $1 billion.

So we have $7 billion in resources. I am not willing to say that I think that these $7 billion are being spent in the best way possible, if we have with our jails the largest mental health facility. I will point out, by the way, that the cost of jail is $130,000 a year, not counting any other costs. Many of you are mental health providers. I wonder how many of you have programs that actually cost more than $130,000 per person, per year. I am guessing not many. That is a lot of money to spend to keep people in a place that makes them worse.

All three of our PES's—Psychiatric Emergency Services—of the three hospitals are running, at census, at a number larger than the physical space is supposed to hold. I cannot make it better by hiring more staff because there is not enough room for people. It is not about staffing; it is the physical structure.

Our inpatient wards in DHS are, by the way, a major mental health provider. That is another thing that I noticed a little bit in the dialogue: the assumption that DMH does mental health services and that DHS does health services. But both services are being provided in all the county inpatient psychiatric services, in all of the county psychiatric emergency services, and in large amounts of outpatient services as well. So we are not new to the idea. We are not separate from you. We are part of you. We want to be closer to you. I want to go to the questions.

Facilitator: It is a list of about eight questions but of course the screen can only hold up to six. So feel free to address them in whatever order you'd like or to collapse questions as well. It's up to you.

DR. KATZ: I will go in order. The things that I am proudest of in terms of mental health, and they are areas that Marv and I have been working on, that I certainly would like to intensify, is identifying other sites where people in crisis can go that is not a psychiatric emergency room. I believe that psychiatric emergency rooms make many people worse because you have got the fluorescent lights, the tight spaces; they're frightening places. If as a service provider in the community you have never been to one, call me up and I will take you because I think you need to see what that end of the spectrum looks like and the importance of identifying other places.

So one of the things that I did with a nonprofit in San Francisco, some of you may know, Progress Foundation, is we created an urgent care center and one of the things that was creative about the urgent care—because Los Angeles also has urgent cares but not quite like this one—is we identified a two-sided house in a residential neighborhood: one side was urgent care, up to 23 hours, and the other side was crisis residential. So you would come, and if you could go home, great, and if you needed to stay then you would stay on.

	One of the things that Steve Fields—who is one of the people who taught me about the importance of community health and I have remembered this when I think about why it is so important to me to change the psychiatric emergency services—always said is the first thing we do when a client comes in crisis is we take them to the kitchen and we teach them about cooking and that process helps to slow down people, helps them to recover their inner energy. I hear a lot of that great work going on in Los Angeles. I think it is terrific. The second question is about the recovery model. Certainly what I have seen about Los Angeles has made me think much more about how we can incorporate more of the recovery model both for taking care of people who chronic illnesses that require good self care. I think diabetes would certainly be the first one I would think of, which often occurs with depression. It is a little bit unclear: Does the depression cause or worsen the diabetes? Does diabetes worsen the depression? Diagnosis obviously matters, but what matters most is how you help people to deal with those issues. We have a lot to learn about how to increase empowerment. We have a group at Rancho where people have longer hospitalizations. Rancho is on a rehab model and it is a special facility for people with spinal cord injuries and other severe neurological diseases. People tend to come for outpatient care. They have peer supporters who go around and help people with new injuries to feel the sense of a sense of hope about what their future is. There is the most amazing person on two titanium high heals you have ever seen. You have probably never walked on titanium legs, but this person does. And it really gives people a sense of hope. In addition, we also have a group in ambulatory care that includes clients, patients and providers. We also have a group in the High Desert, but I think there is more. I also want to say that for all of us community empowerment is journey. It is not an arrival. And so I want you to tell you—and I have a habit of being direct, which is not always good—that you as a group are not very strong at this moment on clients. I think that is a problem. When I did Ryan White Care Act work, the mantra was a third, a third, and a third: a third of the people had to be people with HIV/AIDS, a third of the people had to be gay and lesbian because that was who was the group most affected by the epidemic in San Francisco, and the other third had to be people of color. I do not want to intrude on exactly who you are but in most of the introductions earlier I did not hear ‘client.’ I heard ‘agency.’ And I would say, again, for all of us empowerment is a journey; it is not an arrival. If Los Angeles has arrived at cultural competency in the mental health arena and Los Angeles thinks it has arrived at client empowerment, you are not there. It is like that old Zen saying, if you meet someone who says he is Buddha, he is not. It is a journey. , We can all do better. There is always an opportunity to include more client voices. [Audible clapping.] Thank you. This next question asks, ‘Are you at all willing to reconsider your position in support of a health agency…and develop a strategic plan for improving…’ Well, obviously the decision of what happens is ultimately that of the Board of Supervisor’s. I am going as support what I believe is the most effective way to improve care in Los Angeles, which is actually the same thing Marv said. I think we have to allow different people to have different opinions about how to do that. So if the question is, ‘If I believe that a health agency is the best way to do it, would I change my mind?’ I would say, ‘Not if I thought it was the best way to do it.’ Again, I think this has to do with whether life is a destination or life is a journey. There are people, as you know, who feel very strongly against the creation of the agency but there also people who feel very strongly about the creation of the agency. I do not think we

need to demonize either side. I do not think that anybody has the 'capital' to say, for example (I will say it in its most explicit way, with no offense), right at the moment you are not a group of consumers. But even when I talk to consumers, there is a whole other set of consumers that are on Skid Row, in jail, in PES, and in the inpatient psychiatric units and they also have voices.

My interest is mental health, public health, and health services, regardless of where people are. You have a fantastic community system that is something to be deeply proud of, but it is not a reason to not improve the other populations.

For people who suffer from mental health, would a health agency be better suited to deliver integrated services? So here I will just ask you do to a thought experiment for a second. You arrive at a place. I know many of you are caring service-providing people; you want to take care of people's health needs. Do we really think that any of us would have suggested, 'Okay, well let us put physical health services in this department; let us put mental health services in this department; and let us put substance abuse services in this other department. Let us make sure that all three departments have different eligibility requirements, so that you have to bring your documentation each time. If someone needs services let us just give them a phone number and tell them to call the 800 number.'

Would any of us really design it that way? Is that really how that would start? You cannot ignore culture, you cannot ignore history, and those things do matter. But I cannot imagine that that is how we would design the system. I just cannot believe that we would say that we would want to have our health services in three different departments with the recognition that many of the most vulnerable people are not sure which problem they have, and often they have all three. I can accept that because of bad history it is just not possible, and that there is too much bad feeling. I can accept that. I do not think that it is a great answer, but I can accept that and that may be how it all goes. But I cannot believe that anybody creating a system de novo would do this.

Because this comes up sometimes in discussions about the importance of the equal footing of DMH, DPH, and DHS, I will tell you I do not really care about departments. I am interested in people. Just to illustrate, if you say that it is really important that these three departments be on equal footing, what about substance abuse? They do not get a department? They are buried in public health. Why is that? We do not think that is important? So if we are saying that departments are important, what about AIDS services? What about elder services?

At some point you need a way to organize things. I get it. Everything cannot be all mushed together. There are discipline issues; there are financing issues. But I am just not prepared to say that I think that having these three key services—and many people need all three of them—belong in three departments and that that is just the sensible way to go. I do not agree that simply having the department leaders meet, but maintaining the three silos, is the most efficient way to do it, either.

Can good things happen? Yes. Cindy and Marv are great people. I would say (and this goes to why an agency is needed) we have not made that much progress and we like each other. There are department heads in Los Angeles who will not talk to one another. We have never had that problem. There has never been, certainly in the four and a half that I have been are, a moment of animosity. But still, you are running a department; you are focused on the things that your department is supposed to get done. It is very hard if we are not aligned and if we have not agreed on, 'what are the things that need to get done?'

I also want to address here a funny typo, or I do not know if it is a typo or it is a pun. It is in the report about the alternative proposal for an

office of integration. It is an incredible report and compendium. You were working from not a real transcript; it is just somebody at a public health meeting taking notes. It says that I spoke in favor of a 'single eligibility doc' which was interpreted to mean a 'doctor.' What I spoke in favor of was a single eligibility 'documentation.' The idea is that if I see somebody and they need a different specialty service other than mental health, they do no need to be re-eligibilized. They are in my system already so I send them to the other person. I do not care to give them an 800 number; I make them an appointment. They do not have to bring their documents for eligibility. We could create that in Los Angeles. That is an achievable goal. I do not know what a single eligibility 'doc' would be if it were meant to be a medical doctor.

In terms of next steps, it could be that the Board of Supervisors decides not to act. So I would agree with Marv here that good things have already happened. I think this has been a healthy conversation. I would be first to admit it did not start out well, but I think things have been learned all around and I do believe that Los Angeles will be better off whatever happens. It is perfectly right to raise the issues of joining people and it is perfectly right to resist the issues of joining people; and there is truth and goodness in both and that both may lead to something better happening.

So here is one thing that I think better happen. DHS has always administered the 'Measure B' funds. These are funds that go to private hospitals for providing trauma services. Because we have this huge county, 4000-square miles, there are two county trauma centers that we run, Harbor and LAC-USC, that would never be sufficient for 4000-square miles. Trauma centers would be very expensive to run. So the voters approved Measure B and we fund private hospitals to be trauma centers.

We are at a new time to be looking at what we need from trauma centers, time for a re-funding allocation. DHS's recommendation to the Board is that hospitals that provide LPS services should get additional finding. Some hospitals have actually given up their LPS service, which contributes to more overcrowding of existing places. Overcrowding—I will point out and many of you already know—is one of the worst ways to make people with mental illness better. Crowd people together who are all in crisis, make them wait a long time, and leave them in a hallway because there are not enough rooms. This is the way we are using money that has traditionally gone for physical health services for essentially mental health services.

The point is that if we were not in the midst of this discussion this would have necessarily occurred to us. If someone had said to me, 'Why don't you do that?' I would have said, 'Great idea.' I do not think that this discussion was required in order for us to do it, but the point is no one has said that to us. No one said, 'Gee, why don't you use some of the Measure B money to try to keep the remaining hospitals seeing people on LPS holds?' No one suggested that. It has not come from anywhere; it came from us. I think that is more on my mind…the connections.

I also would have redone the bidding process for My Health LA, if the bidding had occurred this year as opposed to last year. Because if it had occurred this year, in the face of this discussion…My Health LA is a way that my department provides funding to community health centers, mostly Federally Qualified Health Centers (FQHC) for the care of people who remain uninsured—for those not eligible for Medicaid. So what I would have done in retrospect is I might have looked for, 'Are there some natural groupings?' I know there are particular mental health practices, clinics, that work with specific FQHC's and there may have been ways to draw up that Request for Proposals differently.

But it was not particularly in my head. I was continuing a program that has traditionally been about health services and certainly it services many of your clients. So the RFP could have been tailored better. It could have been tailored to really try to connect people who are in mental

health practices to the physical health needs that they have.

I will always come back and say, 'If you have three smart caring people running departments get them closer together, do not get them further way.' Do not get them to be focused on 'their' thing; get them thinking about what 'we' need. Marv and I have talked about a different counter example. I was extremely upset when I came here to Los Angeles, because one of my early memories when I came and had a tour of the Olive View Community Mental Health Center. It is one of the most beautiful centers. It is a center that really says 'rehab' with the physical space. The physical space does not say, 'Psychiatric Emergency Room,' it says 'rehab': the woods, the natural light. And then I got to Olive View today, and they are full beyond their census. I'm like, what's going on? How can this be?

It is not Marv's fault, and I do not know how long ago this happened, and besides that is not the point. The point is that this is what you get when you have silos. I am sure that DHS is guilty of it, and I am sure that DPH is guilty of it and I am sure DMH is guilty of it because that is how departments work. Nobody means any harm. That was not the intent. But you naturally are focused on what it is that the people you are working with want. What do the people that you are working with need? I mean, who could expect anything else of the best departments?

That does not mean that that is a right answer, and we are fixing it. Also, because I do not believe in a polarizing discussion, mental health made the decision that they wanted DHS to run that part of the facility. So that is why I do bristle a little bit at the thought, 'Oh, health services, what do they know about mental health needs? They want to only focus on health services.' I do not even know how you distinguish. Certainly I do not intellectually or in my practice distinguish between both. People come with their set of issues and good clinicians—and I know many of you are good clinicians—deal with those set of issues, whatever they are.

One thing I want to say about fully integrated counties is that whether coming together as an agency is the best choice or not, I think we can lower the volume on feeling that it would be catastrophic. All the other counties are organized in an agency. Some of the counties, including the one I came from, were a single department. (One department is not on the table; nobody is suggesting a single department.)

I would say in the 13 years that I ran a single department in San Francisco, nobody ever said that mental health should leave. Nobody ever said public health should have left. There may have been people who wished it, I do not know. I am just saying that in a very public county with eleven very public members of the Board of Supervisors who took all sorts of positions (including one call I got on whether or not the Department of Public Health would agree to regulate the quality of medical cannabis, and I sort of thought about it, and I said to the elected official, 'Well, I am sure there would be no shortage of employees who would like that job but it is still illegal and I do not know how I would do that'), in a city that suggested the health department take on the regulation of the quality of cannabis—being able to say how potent it was and free of spores—nobody ever suggested that mental health should leave.

So, my suggestion is whatever we do, I do not think we have to demonize one another. I do not think that if the agency goes forward, it will be awful; and I do not think that if the agency does <u>not</u> go forward we will stop making progress. I do not think that we have to be so negative. I do not know that there is any proof, and I am not even sure how we would know that. There are a variety of counties. Even if we said that an integrated county were better or worse than the one in Los Angeles, we would probably feel that that other county was comparable or not comparable to L.A.

Facilitator: Dr. Katz, maybe 5 more minutes?

Dr. Katz: Okay. I'm up to question seven so I think I am good. For question seven, I do not have a lot to regarding the 2007 case of a seven-week baby dying. It is obviously a tragic, horrible thing that happened but I do not know anything about the case. It pre-dates me. Certainly it is the job of service providers of whatever kind of to protect children, elderly and vulnerable populations and that is something all of us have to hold each other accountable for, making sure that an incident like that never happens.

I have already talked about housing. I did 1400 units of supportive housing in San Francisco. As a health department, we do not focus on the economically homeless, even though I think that is a great cause. Our cause is the chronically homeless, finding people who have been on the street greater than a year, almost all whom have serious mental illnesses and/or really difficult substance abuse issues.

We set up a clinic right on Skid Row. An as an important as part of my philosophy, you do not want administrators in buildings; you want administrators close to the clients they take care of. They deliberately designed the building with big glass storefronts so that people who are working in there (the social workers, nurses, case managers, doctors) never forget what it is that they are trying to achieve. We built 600 housing units. I had mentioned that earlier.

I would say that I know less about employment services but I certainly believe in them. Productive work is the best way to help many people. We have implemented a similar kind of peer model around community health workers, or *Promotoras*. Certainly the people at Rancho, who are the peers who have gone through similar kinds of neurologically devastating injuries, show how great that model is.

We talked about cultural competency earlier. Again, I want to say that it is a path, not a destination. None of us arrive and all of us need to work at it. One of the things about an agency is, again, you are bringing more people with different kinds of training together. When you bring people who come from different perspectives, that is in fact how you increase cultural competency. Put people in contact. If you have a group of people who are in a deeply medical model, put them next to people who are working with a social model. Both sides will learn; everybody has stuff to learn. Nobody is perfect, nobody is fully evolved, and we can all do a better job.

Facilitator: Thank you so much for your comments. Can you stay until 11:30? This will give us 45 minutes for the SLT discussion and 15 minutes for public comments.

Dr. Southard: I just want to correct a mis-impression that you may have gotten from the introductions. Not every client identified themselves as a client. They may have been a representative from a Service Area, and that's how they introduced themselves, but there are many people with lived experience on this group that didn't identify themselves as such in their introductions. [Audible applause.]

Q: I'd like Dr. Katz to answer question number three in its entirety because I don't think he did and one of the major concerns I think all of our constituencies have had from the beginning is that we have a fundamental disagreement about how things can get done in this county most effectively. Dr. Katz has the opinion that it is the agency model and there is a lot of discussion in the document about a lack of authority that would come with collaboration and such. Again, from our experience and from everything that we have heard from all of the constituencies involved with the coalition we put together, there is a fundamental disagreement that there is a need for a hierarchal agency model as opposed to

a joint problem-solving collaborative approach. So I would like to have the question read and have you respond to that particular question.

Facilitator: So let me read the question for everyone's benefit here. 'Are you at all willing to reconsider your position in support of a health agency?' [Referring to person who asked the question] And that means to you that the health agency as proposed in the report.

Response: Yes.

Facilitator: Which, in your estimation has a hierarchal aspect to it.

Response: Yes.

Facilitator: Got it. Dr. Katz, based on what you have heard so far from the stakeholder process and objections to the health agency model that have been articulated, would you be willing to not 'just commit but honestly commit' (a very strong rhetorical device included in the question) to the best of your ability to work collaboratively with both Cindy Hardy and Dr. Southard to develop a strategic plan for improving integrated care in the county? I'm assuming over the next six months, regardless of the decision by the board.

Response from person asking question: Well, yes, as an alternative to the health agency…I remember one time fighting with DCFS for months and months over some contract language and [inaudible] at the Board of Supervisors meeting saying, 'You guys go upstairs for the next two hours and come back with a solution,' and we did. So, again, I think the key question here is if there really is a true commitment collaboratively and everyone likes each other, you are all very smart people, you have strong staff, and you have support potentially from CEO's office. In our opinion, there is no reason why, at least as a starting point the three departments and the department heads cannot sit down and over the next six months commit to developing a strategic plan to improve integrated care in the county and then work collaboratively to get that . . .

Facilitator: Without having to use the health agency option.

Response from person asking question: Yes, without having to go through a health agency model.

Facilitator: Okay. So I think your question is clear to me. I understood that Dr. Katz said earlier that people could agree to disagree on that point, but let us hear what his thoughts are on your question.

DR. KATZ: We should agree to disagree. I do not like to term 'hierarchal.' If that is true then I run a hierarchal department, Cindy runs a hierarchal department and Marv runs a hierarchal department. Generally, when you run departments, Marv doesn't say, 'Okay, children's services, elder services, all of my services groups, why don't you figure out the allocation of funding? You know, come back and tell me. Figure out your staffing models.'

Response: We do, we do…

DR. KATZ: Well, I do not know then why you have a department head. Then we should change the name. It is normal in government to have somebody, a person, who runs a department, an agency. Again, reasonable people can disagree. I do not happen to agree.

Response: That just does not answer the question.

DR. KATZ: I am working on that.

Response: Go ahead, sorry to interrupt.

DR. KATZ: I think I did say that I am always willing to reconsider my position but I have not heard an argument that makes me believe that a health agency is not the most effective way to provide services and if someone makes that argument, convinces me, then I will change my opinion.

Response: Yeah, okay...

DR. KATZ: If the Board decides that its priority is the development of the strategic...I will say a strategic plan, which is very valuable, is not integrated care; a strategic plan is a strategic plan. So I have higher expectations of the next six months than the creation of a strategic plan. I have an expectation for myself, what I would like to see, is markedly more integrated care and I do not think personally, but I totally respect people who have a different opinion, that the best way to do that is through an office. I believe the best way to do it is through the creation of an agency.

Response: But you did not answer the question about whether you would commit to this process. It is not about the Board; it is about you. And as the director of DHS, one of the three departments and certainly somebody that has been leading the advocacy of a health agency model (I do not think there has been anybody that would question that), would you commit as an alternative, again, to really, and again we understand it is all about integrated care, to develop a strategic plan to improve integrated care? Would you be willing to make that commitment? You got to start somewhere and you are not going immediately start integrated care without some kind of a plan. Nobody would, in terms of how you would prefer to do that. So the question is are you willing, as an alternative, to sit down collaboratively with the two other department heads and develop the strategic plan to make this happen?

Because regardless of what (and I think this is where the disagreement is) the question is (and we have heard multiple times is there is not enough authority in this collaborative model) there has to be some kind of authority. Everything we have heard from all of our constituency groups that we have talked to—and if you look at the coalition list it is heavily community based, a lot of grassroots, ethnic minority organizations—there is a fundamental belief that if there really was a commitment among the three departments (and you are very smart people, very committed; I do not question your commitment, your clients; you are in public health, you certainly have a commitment to that); if there really was [a fundamental commitment]—for the three smart people that you are—a commitment to sit down over the next six months and develop a strategic plan and then work to implement it, you could do it.

DR. KATZ: I will only say you are a lawyer and I feel like you are trying to treat me like I am testifying what you want me to say. But I have a

career of not saying what other people want me to say. I am interested genuinely in making the care of people in Los Angeles better and I'm going to advocate for the model that I believe does that and that is how I am going to respond.

Q: I do not agree with you and I do not agree with [person who asked previous question] in that way. One of the things that the Mental Health Services Act has forced us all to learn in this room is that the best planning goes on when we have a stakeholder process where we reach consensus and where we do say, 'How many people do you need on your staff to be able to do this job? And what resources do you need? What is going to make the difference? Is having flex funds going to make a difference rather than just having money here, etc.?'

So the problem that I have with this whole process is that we are not working for consensus, I mean, that is what the MHSA did. It taught us how we had to work together with the best and the best way of doing it is from a stakeholder's process going up. I do not want the three of you [DHS, DMH, DPH] to sit in a room and plan something because I know by definition that we are not going to get all of the voices that need to be heard in that room.

What I am concerned about, and I actually think that our goal has to be towards integration of the three departments…I do not have a problem saying, 'Okay, now we are integrated and we are going to change it right this minute and we are going to watch where everything falls…and we have got people who are not on board so what is that going to look like in terms of how that is going to work or whatever?' So what I would like to see, I am not against the idea that we integrate at some point, but I think we need to have a strong stakeholder process where we all get together and we have a facilitator who can help us work for consensus on coming up with a way to deal with this.

What I see is that although I see that you are very educated and knowledgeable and whatever else, I do not see you understanding all of the issues that there are in mental health. I would love to have the opportunity to be in a room with you and the rest of the stakeholders and to come up with a plan that is going to work for everybody, that is going to make us the best health agency in the country because we have worked through consensus and not through, 'I am in charge, I am going to make this happen, I have got the votes on the Board of Supervisors.'

Facilitator: Your reflections on that?

DR. KATZ: I think that is very well stated. I would certainly look forward to being in that room with you and the other people here. I would say that when and, I think this is one of the sort of cultural rifts in the discussion that is hard to resolve, is that the Board, which is, we should accept, a democratically elected group. We elected the five of them. They also feel that they have responsibility and I think the way that they see it is that this was not meant to interfere with what you are talking about.

I understand why it has, but the idea is that the Board makes decisions about how it organizes its departments, its services, broadly speaking. I would be the first to agree with you, that if you are trying to figure out how to serve an individual you would not do that a Board level, you would not do that at an agency level, you would do that with the people who are closest to that person. I would 100 percent agree with that.

Q: Thank you for being here. We have had a couple of opportunities to have to conversations and I have appreciated them. I am a team leader with Mental Health America Los Angeles in the Antelope Valley. I happen also to be a mental health consumer in recovery and a substance abuse consumer in recovery, and I do not think that I am alone at this table and in this room and thank you Dr. Southard for pointing that out. I

believe we are very representative of our population.

My question is, and I think you are going to start to pick up a theme here, and it is a fundamental flaw, I believe, in how this process got started and why it should not necessarily go forward in the way it has been proposed: Why was this process begun with an agency model already identified and not a needs assessment to inform a variety of possible agency models that could have been then researched, publicly vetted, and decided on by the large constituency? If that had happened, where other models were proposed and they are effective models, would you be willing to consider them and possibly support them?

DR. KATZ: To answer the second half of the question, I said I would consider any model and try to judge based on whether or not I thought it would be the best way to deliver services to Los Angeles. However, the Board takes actions that the Board feels like taking. Again, I will only say as part of people's understanding, at the time the Board took this action, the three of us reported to a Deputy CEO. When the Board eliminated the Deputy CEO, nobody even mentioned them. The Board completely changed the organization and nobody said a word. Nobody said, 'How come we were not involved? You have changed . . .' I do not know how long it was. The Deputy CEO dates back to Sheila Shima, so I do not know how long. But there were was not a single, 'Boo, how dare you completely change the organization?'

I think from the Board's point of view, and nobody here has to agree, they did not feel that proposing to change of the three departments from a Deputy CEO to an agency was a major change. Again, I am not saying that it did not, but their point of view was, as they said at the meeting, 'We do not want to cut services; we do not want layoffs; we do not want to change services.' That was not their thing. I understand how it has rolled out and I understand the problems, but I think you at least have to understand what was going through their minds. They were changing, or proposing a change, to the supervision of three department heads from a Deputy CEO to an agency.

Facilitator: I think it goes without saying that as a facilitator I can neither determine your questions nor can I force anyone to respond in any way. My role is to just keep things as civil as possible and focused on learning. Next person…

Q: My question was number four. To be more personal about it, my son suffers from co-occurring disorders and he has not gotten integrated treatment. His co-occurring disorders have deepened and gotten more tragic and more near-death experiences. When he is in need of detox there is absolutely no detox in Los Angeles County that takes Medi-Cal. That is abysmal. When he needs co-occurring treatment there is residential care that really understands it in this county.

I think that public health needs more money, totally, because how can they help with this detox and how can you work together as integrated agencies to actually do practical things like have detox for people so they do not die on the street and then also have a place for them to go afterwards…how to get help in jail? The public health does not give any programs for treatment in jail for co-occurring disorders. This is crazy. Why do we have such recidivism? I am on Jackie Lacy's Taskforce, and really what we need to do is spend the money and actually have things occur that treat people. Like you said, on Skid Row, people that have these serious disorders and the people in jail, so when they get out of jail they can actually move forward and not get more ill.

Facilitator: Feel free to comment on any question Cindy or Dr. Southard.

DR. SOUTHARD: As you know, we have similar experiences in this regard in the ways that integrated care does not happen and the consequences when that is not available in the way that it ought to be. But I think this is one of the areas where our three departments are already moving forward and trying to work together and the change that needs to happen is focused on actions that need to take place in Sacramento.

I know all three departments are putting pressure to make sure that Sacramento delegates to counties the authority to implement the new drug and alcohol benefit under Medicaid that would change everything that [the person asking the question] is talking about. If that benefit really becomes available it makes all three of our departments' jobs much easier. The change needs to takes place. None of the three of us are in charge of making it take place but all three of us are putting pressure where we can to make it take place as quickly as possible.

When it takes place, for example, the mental health department has offered to do the site certification for the Medicaid clinic since we already do that for the mental health clinics. If we could do that for substance abuse, it would facilitate the bringing on board of those entities that we really need to create better recovery.

CINDY: Thank you for allowing me to be here as part of this meeting today. Thank you, Dr. Southard, for inviting me and thank you, Dr. Katz, for all the comments you made earlier. I think it was very transparent of you to share all the thoughts about this health agency and the work you are doing.

In terms of your very eloquent questions, there are some solutions that are coming with the 1115 drug Medi-Cal waiver, which will help us to better serve our communities, create a better linkage of care and create a better system of care here in Los Angeles County. The other thing that we need to look at, and your point is very well taken, we need more funding for alternatives to jail and substance abuse treatment in the community. We need to think not just about diversion programs for mental health but also for substance abuse.

Response: Especially if they are co-occurring because that it makes much more serious.

CINDY: Exactly. Just for the substance abuse part, as well because we know that about 80 percent of the folks in our jail are dealing with substance use disorders; and so it would be really important for us to think about diversion in those contexts as well. So I really appreciate your comments.

DR. KATZ: Well, first, I am sorry about your son, and I hope you keep working with Jackie Lacey. She is a pretty amazing person. While I do think that the waiver would help, we have the money. It is $130,000 a year. That is the money. So, and again, remember that is not covering the mental health; it just the custodial part of the care. That is our money as a community to spend. That is our tax dollar. Jail is 100 percent General Fund. There are no federal dollars; they are state dollars.

If we as a community decide that we are going to start spending the money on diverting people, and I agree with Cindy, it should include people with substance abuse issues. In San Francisco we had a sobering center which does not exist here. People get locked up here for public inebriation. Public inebriation; people go to jail. We have the ability to change that. We actually have the money. The waiver would make a lot of things easier.

Q: You talked about several different things that, I think, many of us agree on: that jails should not have so many people with mental disabilities; there should not be so many homeless people on the street. Maybe this question is a little bit of a follow up about money, because you seem to imply that money was not the big issue. I am not sure that I follow you there.

Another thing you indicated was when you had a problem with community hospitals taking LPS patients you gave them more money. I think a lot of what is being discussed today is how we prioritize the money. I think there are old wounds here about how money was taken from community mental health and put into hospitals.

At least for me, one of the key issues that that has not been resolved in the conversation today is: How do we make sure that [inaudible]? Certainly I am not questioning your dedication to making this community model work, but there is a lot of pressure to make the emergency hospital system work. There are a lot people employed there. We do not want our hospitals to fail. Bringing things together in terms of pots of money potentially endangers those pots of money that are being used for other things. That is the concern I have and I wish you would address that a little bit.

DR. KATZ: I am interested in these questions because that is how you get stuff to happen. Just to start where you ended, the issue about Measure B is that that money is going to trauma hospitals. It has always gone to the trauma hospitals. The question is what do you want to give them the money for? I think what I learned, in part because of the integration conversation, is, 'Look, why don't we use that money to increase their effort to provide good care for people with mental health crisis.' They were going to get the money, so I did not find a new pot of money. What I said is we are figuring out a new allocation. Let us take into account not just the trauma, meaning you got hit by a car accident, but the trauma of being in acute mental health crisis.

We did 600 units of housing last year. How did I do that? I took the money that I saved by getting people out of the hospital and it was directly related to the first time when I was here. I think two weeks into my tenure I went to LAC-USC and I was asking doctors what the problems at the hospital were. They said, 'We have all these homeless people that we cannot discharge.' I am like, 'Well, why can't you discharge them?' They said, 'Well we do not have a place to send them.' I said, 'Why can't you just discharge them to housing?' They said, 'We do not have the money.' I am like, 'Well but you are spending $2,000 a day for them to be here. How can we not have the money for housing if we are spending $2,000 a day for them being here?'

I feel it is the same conversation around the jail. You are spending—we, all of us, are spending--$130,000 in custodial per year. Why can't we use that money for a different purpose?

Q: Do you foresee that the Board would go along with the deal that if we create more services for folks they would cut the money from the Sheriff's budget and put it into health?

DR. KATZ: It is not just that they would; it would happen automatically. So the way it would happen, which is exactly the hospital model…what happens is if you need less…What drives the cost of a jail? The number of people you need per inmate, right? That is what you are paying for. The $130,000 you are paying, for security reasons. The larger your jail is, the more expensive your jail is. It is all about staffing.

I think Jackie Lacey is a firebrand who really wants to change things. I think the Sheriff recognizes that keeping people with serious mental illness is dangerous for them. I think that the Board realizes that they have to build a new jail, and it is very expensive to build a new jail. The public does not like to pay for jails; it is a very unpopular cost. So, to the extent that we figure out how to get people to other things…

Then we have the additional plus that under the ACA, this is in some way a game changer. At the moment, to the extent that we could get changes, and I think with Jackie's help we can, we can give people suspended sentences. We could then—all of you as services providers—could be providing them with services and we could bill for those service because under the ACA we can have a large number of single adults who once were uninsured that now we could bill for.

Of course, you cannot bill for them when they are in jail and you cannot bill for them if they are under a sentence. But if the judge—and San Francisco has a very active mental health court where judges would sentence people, if you want to use that word, to treatment—and in this moment, as long as that sentence is suspended we could bill for it. So I do think there are creative ways. More money is always welcome, of course.

Q: Thank you again for coming. We were very curious to finally meet you and it has been a pleasure to hear about your background. I wanted to just comment on sort of the tenor of your presentation in the sense that I do not think that any of us believe that DMH either as an agency or as a consumer, that we have arrived. We understand that we are on a road and what we are feeling though, is that under the DMH we are farther along the path than perhaps is envisioned by DHS. I want to be very clear about that. We know that we are moving forward and that we have not arrived.

Along those lines, when you talked about physicians and their interactions with clients who do not want to be diagnosed with mental illness, we work with that every day. I hope that wherever we end up that the agencies look at the work we have been doing under MHSA Innovations, because many of us have started to integrate services. We have indentified the challenges, we have met many of the challenges, although we know that we have, again, farther to go along the road.

When we see physicians interacting with clients, their issues are usually time issues and that they do not have the time to talk to clients because they have that 15-minute time limit. Quite often their answer is 'medication.' Our concern is always the medical model. It seems to be a little bit counter to what we experience as mental health providers.

Lastly, I want to really encourage the stakeholder process. In doing that, I come finally to my question: What does DHS have currently in terms of a stakeholder process?

DR. KATZ: One of the things that maybe could happen under a health agency model is the different specialties teach each other. So I would agree that DMH has a lot of great things to teach DHS, and I hope people would believe that the opposite is true as well. As I was alluding to earlier, we have an ambulatory care group that is a community body similar to yours in charge of ambulatory care. We have a very active group, a residents' council at Rancho. And we have a very highly active High Desert group. Those are our three major groups. There is also a Hospital Commission that oversees a lot of the services. So, I certainly think there is a lot of more room for good things that could happen.

Q: I wanted to say that when this whole thing started we were very apprehensive about the idea of the health agency and what it would mean to client care and to our members, whether there would be things that would happen in terms of their employment. So we dug in, we read the paper, we went to the stakeholder groups and I have come to really turn around in my thinking and see this as a pretty tremendous opportunity.

As a social worker, we are taught to see the person in the environment and to look at every aspect of a person's life. So the concept of integrated care is just very natural and the idea of breaking down the silos, to create opportunities to make that happen more easily, is very appealing. I think my question is a little bit similar to [those of other people], because having watched and been part of this group for years, people are so invested and have worked so very hard. (I personally do not believe in consensus; I think you can approximate it.) But I do believe that people, especially in this group, are accustomed to a very high level of input. I just wanted to have your thoughts on your vision on how that might continue even if a health agency does become the model, which I kind of hope it does now. Thank you.

DR. KATZ: I would want for all of the groups, and public health also has, and maybe Cindy wants to talk about some of the great groups that you have, I think that one of the things that would happen under the health agency model is that we would have a broader set of constituent groups. Again, I think, we would want to keep all of them and that we would want DHS to have learned from the successful experiences, not just of DMH, but of DPH also, of other ways to increase input and other ways of making our care better and more culturally appropriate. So I think there is a tremendous opportunity and I would certainly commit to all of you to wanting to continue this particular process but also wanting to involve you as experts in how we could spark similar efforts in DHS populations.

CINDY: To just briefly comment, I think that mental health really has the model on how to get community input into the programs and services and funding. I have always really respected the work that Marv has done in pulling together a robust community participation process. All of our programs in public health have some form of community input, whether it is our service planning areas or area health officers that are leading community initiatives around population health, obesity prevention.

We have been recently conducting a series of meetings on our community health improvement plan, which is part of a step that we are working on. We are working on it because of accreditation but it is also become so apparent that this is something that will be a permanent piece of what we do in Los Angeles County, going out and meeting with the community about what the issues are, how do they define health in their communities, what can we do to improve the health, what do we do together, because we know in public health we cannot do it alone. It is going to take everybody in the community working together. So thank you for that comment.

Q: Thank you Dr. Katz for being here. I had many questions and you probably already heard some of mine. But what I want to ask you about and what I am concerned about is we want, from the Underrepresented Ethnic Populations, and from the cultural competence groups, we want what we have now in this model and what we have throughout this whole organization. Whatever this decision turns out to be, we want a 'say.' We do not want a 'say' just now; we want a 'say' in the ongoing process as it develops [inaudible] and how it affects us.

I was very disappointed in the proposal as written. It talks about cultural competency as it relates to an organization versus the community. I do not hear the 'community' in what you have developed (or whoever developed it). I am very disappointed in that because that is what this community is about. You get a lot of reaction and pushback because you did not respect that. So I want to know right now how are you going to

make sure that these different groups with their different cultures and with these different needs are being respected in the process of integration and how it is being integrated, so it does not affect us negatively?

More specifically, your whole health agency design is at the operational level and not at the community level. And what we are really apprehensive about and why we are pushing back so hard is because we do not see the details of the outcome—how you are going to do that when it relates to us in our community and how are you going to respect us in your process. As many of our colleagues have already said, we are different advocates groups here but we are all respectful of one another and we all try to understand each other's needs and we support each other to that need.

This department has done an outstanding job of hearing the community, trying to do the best they can. Are they perfect? No. But they have done more than any other organization I have ever seen do it in government. Greater bureaucracy is not always the best bureaucracy. So, unless you can show me more than what I have seen—because the report is just global and is a promissory note on something that may never be delivered at the operational level at the community—then I am still going to be apprehensive and I am still going to be guarded for the community. So I am hoping that you can give us more details then what we have been hearing.

Facilitator: So the incorporation of underserved ethnic populations and cultural groups is a concern.

Response: Yeah, absolutely, but I want to hear what Dr. Katz has to say…

DR. KATZ: I understand the issues you raise. They are very serious issues. I absolutely commit to continuing the efforts that are already ongoing in DMH and in DPH and DHS, and in trying to expand them. I cannot prove what will happen in the future. You cannot do that. The future is the future. I think people have to judge me by who I am and the kinds of things that I have worked on and my openness to learning and to doing this in a better way.

I am happy to work with you and happy to figure out how to do it. Again, I want to say that if the issue is that DMH does it better, that is not an argument against an agency. That is argument for an agency. Again, I think DPH does it well but I am willing and prepared to say that I think that this is an area that DHS can do better. So teach not only me, but I have 18,000 employees. Let us see that as a potential positive, not as a negative.

Response: It is just that it is a medical model, and everything I hear is about the medical practice and how this is going to be done in a medical way. It does not always honor the whole process across the board. As a community, we honor everyone so we want to make sure that the process is respectful to all people's thoughts and needs. And the commitment I have really been looking for from you, as well as the others, is the commitment to create a process that is constant across all of these entities that respects and gets input from the community as you move forward, every time for [inaudible] item. It does not mean just for now, just for this project, but ongoing forever, to improve the process.

DR. KATZ: I commit to that.

Q: It is clear to me that you have enormous experience and that you are a visionary in what you want to do and no doubt that you are well

intentioned in how you want to bring this on. I think the issue is, and I think you have heard it, but the theme here is trust. The question is there is so many unanswered questions in an uncertain economic environment in terms of future funding, [inaudible] bureaucracies and trying to merge these cultures because we know those things do not happen quickly. A lot of information gets lost and the decision making process gets foggy, and we are all concerned about that because we want to see fidelity and integrity in a process that brings forward our views.

I think that the real question here is what kind of road map is in place in terms of procedures, incrementally, in the development of how these decisions will be made so that these new programs and the policies that undergird them can go forward. I do believe it could be a big positive from the standpoint that if you do it successfully, you will have much more power in terms of the state, in terms of funding and policies, etc., because it will be an uncertain environment going forward. But we want to have the greatest input we possibly can. I do think that there is this concern, the underlying concern about the winners and losers and how these decisions will be made once these pieces are put together and how long it will take, because we have a cohesive system in which communication can be understood as a process as effectively reaching everyone and that everyone has input.

So for me it is really a question of creating those mechanisms and assuring that we have some sort of clear, transparent process as we go forward so that we know that trust will be there in a situation which I know is very volatile because the Affordable Care Act. We do not know under what conditions [the process] will exist, and we know that we have big new pieces in this, like the community that was mentioned; that whole piece has really not been mentioned here in these discussions and it has to do with setting up, as we have done here, learning communities and understand how we can get community support in the creation of health and in doing the best we can to lower the burden of disease in communities.

DR. KATZ: I agree with your comments. I think there is a little bit of challenge for all of us. Is it really possible to plan for all of those things when in fact we are also involved in a stakeholder process to inform the Board of whether or not to do it? So it gets a little bit challenging because to be true to the process that we are currently involved in, if it begins to seem that—because there is a long elaborate road map about what would happen if there were an agency—then it might be disempowering to the people who feel there should not be an agency.

So, for better or for worse, part of the idea of this particular part of the process that we are in is trying to elucidate for the Board what are the opportunities and what are the challenges. The one thing that your point about culture reminds me is, I will say, I find that not a very compelling reason not to become an agency. Because if we cannot resolve [how to work across the different departmental cultures], how can we expect our consumers, our patients, and our residents to resolve it? It is challenging but I do not think that it is acceptable to say that because we have different cultures we should not form an agency.

Response: I guess I would just say it is about the process of how we create that new culture. How do we participate in creating that new culture?

DR. KATZ: Right, right. At least the way the process is set up right now, and again, you know, I think this part can be revisited, but the moment we are at now is the Board has said that they were interested in this health agency option but not committed to it. The process is to inform them about what has been learned. There is now an alternative proposal in other agencies. I think that if they then decide, yes, they want to go forward, that would be the right moment for us to all then reconvene and say, 'okay, so the Board wishes to go forward, how do we do that in a way that respects all of the communities and includes everybody?' But it is challenging to do that while we are also in a process where we

	are all trying to say, 'Well, maybe this is not the right answer.' **Comment**: I am the Cultural Competency Committee Co-Chair and, I do not know if it is just me but honestly I just have to say that I feel very insulted by the comments you made. I just feel that they are very, like, very accusatory: what the Department of Mental Health needs be, what it needs to do and that we need somebody to tell us how to do it. I do not appreciate that. We are all working very hard at doing the best that we can and serving the community that we have that has the needs. And we know exactly what those needs are up to some point, but we are not experts and the reason that we have all of this consumer representation is because nobody knows what the community more than the community itself. That is thing that I do not see in the comments that you have made, that you talk about certain things about cultural competency and so forth, but I am very concerned about the fact that if you are not committed to an alternative position or at a collaborative position, and working collaboratively with your peers, I am not sure how you are going to work collaboratively with the community. In hearing your comments it just seems that you have put yourself in a position that you would be running this agency and that is something I do not think would be the best thing. For me, as part of the Cultural Competency Committee, I am the voice and I take that very seriously. It is very important that the grassroots, that the cultural diversity of the people, that the culturally diverse underrepresented populations are considered at all times and that we work all collaboratively. Thank you. **Q**: I am the co-chair for SAAC 8, a role I take very seriously in terms of my position in representing my SAAC. What I love about it and what has been an incredible learning process is not only the closeness I feel with my other SAAC co-chairs, which take their job as serious, but also in making sure that our voices are heard. So in that respect my one question is, because the SAAC's are a pretty powerful group within DMH. We have had not only conversations with Dr. Ghaly but also with Carol Meyer to really hear our concerns. This kind of ties in with cultural competency as well: How would you envision DHS' involvement in SAAC, because that has been a very underrepresented agency there [at the SAAC level]? As we talk about that integration process and about the trust factor about being able to hear the concerns of the individuals (there is very heavy representation of consumers but also of family members, which has not really been brought up), I would like to hear a little bit about that, so that the process can be (what I think a lot of us feel) a more open stakeholder process and participation in the direction of whatever agency the Board of Supervisors develops. My next question…is: What is the next process with the Board of Supervisors because we seem to be getting a lot of mixed messages about that as well. **DR. KATZ**: On the first one, I would say that this is part of how I think an agency helps DHS, is that it is always easier when you have a well-established group to increase its participation. The hardest thing is to start a group. Having consumers and family members makes it easier to get other people and to see the power in it. So certainly I would commit to broadening that and I think it is an easier to do this, as I have said before, where DHS has much to learn from how DMH has done that.

I do not have any special way of knowing what the Board is going to do. I will review what we know, that the public comments are being accepted until May 30th. Dr. Ghaly's job is to incorporate the comments that she has received and to produce a report for the Board and then it is really up to them. They can take the report and file it, 'Thank very much,' or they can take the report and have a hearing on it, or they can calendar an item. The one thing that we know is that, to the credit of the democratic process, whatever they do it will be agendized ahead of time and there will have to be two votes and there has to be public comment.

I would also clarify that I took this invitation to try to talk about what I might do and who I was, but it is also absolutely true that there is nothing in the resolution that would say that I would be the one who would head the agency. I would also assume that the Board would not make that decision at the time it made the decision about the agency. That would be up to them.

Q: I am really concerned. I have not heard very much about the children or the transitional age youth. I am a parent who raised two children with mental health disabilities. I am also a parent that receives mental health services. I do not hear too much of the family thing. All I hear is that they want to create a bureaucracy on top of what we have, and this is something that was said by other parents at a group, 'Why does the Board of Supervisors want to create another bureaucracy? We have a hard enough time dealing with what we have.'

It is very hard to navigate the systems, and on top of that we are going to have another bureaucracy we have to deal with? If we go to our director, we feel very comfortable going to him. But if he does not have too much authority to answer because he has to respond to another person, where does that leave people that do not understand the process?

A lot of us here, like myself, belong to a nonprofit, grassroots organization statewide. I just do not understand. Where on the line of priorities is mental health going to be? We keep hearing we are all equal but I am watching what happened in Sacramento and that relationship is not equal. So I do not understand. I understand collaboration. I understand working for a strategic plan but I think we have all tried to work with the other departments.

I also know when my son was little I went to his pediatrician and he had nothing to say. I had to wait until he was in the second grade to get the school to evaluate him and go see somebody in the psychiatric unit. Then I went to my medical doctor with his medication asking him what the heck it was and what the heck this diagnosis was. Do you know what he told me? 'Well, maybe you were right.' It took one professional to tell another professional what a parent living 24/7 with a child was doing. So I do not hear none of that, I do not, and I wish I would.

DR. KATZ: First, I want to say good for you for being such a good parent and for advocating for your kids. My hope is that with an agency model (and, again, I want to say that the idea is not DHS is telling DMH what to do) the idea is that in an agency smart people are figuring out how to make sure that kids are getting the right care and that different people have different things to teach. So certainly I heard a lot of about it in the work that I did around the Blue Ribbon Committee for Foster Kids where the issues come up very strongly about the need for integrated care.

I think from the Board's point of view they were not adding a bureaucracy. The three of us reported previously to a Deputy CEO and we currently report to a CEO. It is common in government to report to somebody. The Board reports to the voters. Everybody reports to somebody

and I do not think that their view was that this creates more bureaucracy. Certainly not in my view, I am not a fan either of bureaucracy. I do think that all resources available should go to the care of people.

Response: A follow up, you say the Board of Supervisors reports to its constituency of voters. We are their voters.

Facilitator: I am tracking the conversation, the energy and also the importance of this discussion, so we have been checking to see if there is any flexibility on the agenda.

[Goes back and forth with Dr. Katz to adjust agenda; and Dr. Katz agrees to stay till 11:55 at the latest, including public comments.]

Comment: As a partner department, I am with DPSS, that works with each of the three departments, we often see the struggles that both our mutual clients and the staff that deal with each the departments' experience and in dealing with each department working in silos to serve the same client. So like the three of you, we are hopeful that whatever models move forward will be the one that best moves the individual to wellness and self-sufficiency.

Additionally, I just would like to commend the work that DHS has done around providing stability and non-traditional services for DHS's most vulnerable homeless clients and they are often General Relief clients as well in the area of housing. When I visited the STAR apartments and the Housing-for-Health offices, I was inspired at the thought that this is a health department that is actually creating housing. That was just the kind of out-of-the-box and innovative, and really inspiring that you would invest the resources and the time and the energy of staff to actually do that. I know there are more units coming up and it is really to the benefit of all the clients that we serve.

I look forward to that kind of continued collaboration and forward thinking with whatever agency is coming forward. Whatever is done, it is going to benefit all of our clients because we are all mutually committed to the same clients. So that is my comment.

Comment: I want to thank you everybody that has come today and I want to thank the rearrangement of the schedule because I think this is an amazing conversation. Dr. Katz, I think I am very much like you. I am very blunt, very outspoken, so right now if we can agree to disagree in an agreeable manner, the reason that we disagree at this point is simply because we have not had enough conversation to have a big enough picture so we have opposite opinions.

But I am feeling like I am meeting more family. First I met Carol Meyer. We danced a little. I decided she was okay. [Audible laughter.] Then I met Christina in this room I had a challenge about dating Christina. And now I am meeting you, and I am feeling like this family is growing. But I have one thing. I was with Leticia about some of your words when you first started but I also watched that soften as the conversation in the room evolved. And it was only in the end when you said, 'I believe an agency with smart people will figure it out,' that I really disagree with that. I do not think it is about an agency with smart people that will figure it out. I think it is about building collective wisdom that we bring all of our minds together, we brainstorm about solutions, and then to quote somebody in this room that everybody will recognize, we take one careful step at a time because we do not want to do any harm and we do not want to do any collateral damage.

If we can come together with these kinds of conversations in unity we have two huge benefits. One, our unity will allow us to be flexible as we

come up against problems, as we have to go to Sacramento and say this is what needs to be done, as we go to Washington, we say, 'We need regulation changes.' But two, the process that we all treasure, and we all have our own opinions, our own perspectives, our own agendas, but the process that has been developed in this room has been awe inspiring. I think everybody in this room will say that we value that process and the potential good that we can generate with collective wisdom more than our individual perspectives.

Comment: Thank you very much for being here. I know you will be joining us at our SAAC 6 meeting tomorrow, so we are looking forward to that, so I will keep my comments brief. I personally do love working with Boys and Men of Color and we a lot of our work here uses the 'social determinants of health' factors because those are really relevant to the discussion here, and I just want to make sure that we are keeping track of them, although these have not been discussed so far. However, we explore the root causes of mental health, and this is what DMH focuses on with our 'health neighborhoods' concept.

So I just want to underscore that part (and it only reminds me of our work with our youth), a lot our Boys of Color as well and our youth in general, that we are missing the boat. Every 29 seconds someone drops out of high school every day. I just wanted to put that into the conversation. Thank you.

Q: I am sorry I was not here for introductions but I am a client and I represent all of my fellow clients. I first would like to say thanks to Dr. Southard because he does meet with the clients and he gets clients' input and he makes things available for clients. My question to you is that if all of this happens how willing are you to meet with clients' and take our input on anything that happens for things that are to happen for clients? Because who best knows what works for clients than clients themselves?

I have noticed is that—since I have been involved with this whole thing, and I also volunteer for the department—is that I have seen things change and ideas from clients have been accepted and put into action.

I also look at the homeless situation. What are your plans to also help with getting things turned around for the homeless? As you said, on Skid Row, right next to downtown mental health, it is ridiculous. I was there last week. It is ridiculous how the people, politicians and all, have turned their heads and I have seen the growth of tents and shacks just built on the streets of Skid Row. What are your plans to try to get this turned around or do you have any plans? I would like to hear them.

DR. KATZ: Thank you for your comments and for the work you do. I want to create 10,000 units of housing for people who are chronically on the street, meaning people who have been on the street more than a year. I believe it is possible. We did 600 units last year, including the Star apartments right there on Skid Row. We are planning to do 1,000 units this year and we are doing it on health dollars that we have saved because we know that when people are housed they do not need to be in the hospital for as long a period of time. We have a steady source of revenues.

I think, again, that one of the advantages of the agency is that mental health does things in housing, public health does things in housing, and that by working together we will be able to achieve more housing. I really believe that the answer, one of the things that I believe at the core of my soul, is that homelessness is a curable problem. There are a lot of problems that are not curable. Homelessness is not one of them. If you want to cure homelessness, you house someone and they cease to be homeless. We have never met a person who could not be housed. Yes,

people have different needs. Someone may need to be with a dog, someone may need family housing, somebody may be still using and needs to be able to do that in their room not in the lobby. But we have yet to meet the person who cannot be housed. So I say let us house people.

Response: Okay. How about the first part of the question, as far as client involvement.

DR. KATZ: I would commit to you what we would maintain: clients currently come to see me from the DHS side and I would welcome clients from DMH and DPH. Also, we would be continuing with the other fine directors. Remember that the mental health director is not going away, the public health director is not going away, so there will remain hopefully more opportunities, not less, for client input.

Q: I do have a concern that I heard someone say in DHS, they have groups or whatever, but I do not believe they have a group like [the Systems Leadership Team]. This is what I would like, either they be a part of this group or a group like this that is made up of different groups. I am the past co-chair of Service Area 6 and have been involved since we came out from 'Underhill Services' [spelling?] from many years ago and it was one of my recommendations to take us off from [inaudible] because we were like a stepchild to health services.

When we came out, we grew tremendously. We are not where we should be but we are a long ways from where we were. I want to make sure that nobody up top thinks that they can plan for all of these services; I am talking about all three [departments] or whatever number you are planning to put together. Whatever you come up with, I hope you do it like mental health. They bring it to the stakeholders. They bring it to the SAACs; we have eight of them. They ask them what they think before they make a decision. I hope that that will happen under [the new health agency model], like you said. You do not know if you are going to be the head, but under this umbrella agency, whatever it is.

I do disagree with the umbrella because we already did innovative programs where we put the three services together and called 'no wrong door.' You get all the services you need once you go into one of the places. We have been doing that and proving that it works. We just need a lot more of that.

I think you someone should tell the Board of Supervisors the next time they come up with a big idea, to bring it to the community first. I have said it everywhere I go, but it is not in the written document. Someone read it and told me it is not in that document.

Q: Since San Francisco was raised, we did get some feedback and I wanted to hear Dr. Katz's comments on that from people that we spoke to in San Francisco that had some concerns certainly in terms of mental health. We actually talked to the former director of behavioral health services. The comments were about basically a one-size-fits-all model would not work, where all clients with mental illness, regardless of severity, are treated the same, as persons with serious mental illness.

Also, there were general concerns about: mental health not being placed as a priority in planning; not a lot of collaboration between health and mental health; and the medical model and medication being seen as the primary treatment model for clients. The other thing, related to that, was where mental health was in terms of the organizational structure because that is certainly important in this discussion. Mental health was not directly reporting to you, which is certainly a concern to all of us in terms of how mental health would fit in. I was hoping you could provide a few comments on that.

DR. KATZ: I did not talk with the person, but I did read your report. At least the way you wrote it, it sounded like what the person said, the former director, is these are the things that you should make sure happen in any agency. I agree with all of those things. One size certainly does not fit all. I did not read it as a critique of what San Francisco had done, but again we can disagree respectfully on those issues.

During the time I was in San Francisco, the organizational chart varied quite a lot. Certainly, I was the director supervisor of [name of person] for a very long time. San Francisco took a somewhat different approach, which people here may or not agree with. We decided we wanted to be behavioral health unit, so substance abuse and mental health merged as a single department under a single director of behavioral health. Behavioral health chose to be with public health and it was directed by [name of person], who succeeded me and is a terrific person who had a background in all of those areas, and had formerly been at SAMHSA.

So that was the organization that worked for us. That is not the organization that is proposed here. The organization that is proposed here is the maintenance of three department heads, three separate budgets, and reporting to an agency director with the idea that the programs would still be determined as they should at the level of the people receiving the programs, the service providers, but that the coordinated functions would be at the agency level. But that is not where programs are designed.

I would agree with all of the comments that programs should not be designed at an administrative level. I did not design the program model of the Star apartments. I helped to get the money for the housing; I saw that as my job, and I helped eliminate some obstacles that I did not create nor would I try to create with regards to the development of the housing model—that is, the case management model, the social work, the nursing function, and the medical. That is not best done at an administrative level.

Response: But it was correct that behavioral health did not report directly to you. Is that correct?

DR. KATZ: In the later years…but during the other years, mental health reported directly.

Public Comments Begin:

Q: I really appreciate the candor, the skepticism as well as the concerns of this stakeholder group, such a passionate, intelligent group. Dr. Katz, I am really also impressed with your background. I first met you several years ago at a medical conference and I was impressed then when you told those students that you did not want them coming to you about more research but to ask how you can get doctors working closer with patients. When I look at the dynamics as they exist, you mentioned the jail, they are full of Black and Brown. You mentioned Skid Row, they are full of Black folks.

Just recently, as of a day or so ago, research came out that young African American kids now have the highest risk of suicide rates, twice that of Whites which was the norm for awhile. So clearly our community is endangered and as the co-chair of the department's Cultural Competency Committee I can tell you we do not practice cultural competency throughout the entire system. We are working diligently in that area, but fundamentally, when you take into consideration some of the community's voice, particularly that from the California Reducing Disparities Project, African Americans have clearly said, 'unless you change the system nothing works for us.'

So I am whole heartedly in favor of integration of these systems because now we are 15 years into the 21st Century and disparity has increased. That presents an opportunity for us Angelinos to come together to represent a model, not even a model, a framework in which all of us can be engaged. As I have heard other people say around the table, I think it has been a little bit to ask our panelists to speak about whole systems change when their expertise is in different areas. I happen to be a systems architect and so having sat here for the past eight years and read extensively the Board's and your strategic plans, as well as your budgets over the last couple of the years, with the exception of health services, I have been doing this since President Obama issued the mental health parity in the ACA, which has been showing some success. However emergency room visits are up.

So it just begs the concern that we really need to take an upstream approach and really start thinking about how we can make the system better because, at the end of the day, we are not all going to get what we want, community included. But if we can find processes to reach common ground, therein lies the opportunity for real substantive change. And so with that I would like to hear from each one of our panelists on your ability or interest to include school-based health centers as a hub for moving physicians and our clinicians closer into the community so they do not have to travel ten miles to get care but really meet the needs of the community where they reside.

CINDY: In public health, we also love that model. It is a great way for us to bring in population-based services through a center in the community linked to services for kids and families and we totally would love to work more in that arena.

DR. SOUTHARD: As I am sure you know, that is the whole idea with our health neighborhoods, to incorporate all of the community resources, all of the community strengths together to make all of our resources available in the best possible way to the needs as the communities perceive them.

Q: I am very concerned in losing services for children. Little by little, all the children in schools are losing services in the system. Two years ago, three years ago, the government decided to give the authority of the schools to decide what kind of services they are going to provide. And it is more difficult now. I attended a lot of IEP meetings in my area, which is Service Area 8, and little by little, it is very hard for the parents to get service. And I do not hear, here, service for children.

I am very concerned every time we have big changes because the kids are losing a lot of services and families, too. I am here today, and what you said about you do not know about the future, we do not know about the future, but we need to have a vision, at least. Where will we put our community and our children? This is my biggest concern.

DR. SOUTHARD: The specific thing that you are talking about is the shift of 3632 services from the County to the schools that took place a few years back. We share those same concerns. It has been our perception, the perception of many in the community, that although the dollars moved to the schools, the services have decreased.

Now the schools have their own issues and their own budget problems and that is probably why it happened. The thing that is happening now is that Senator Bell is calling for a examination of those expenditures with the Department of Education, so we can look at that issue because we know from our clinics that some of the people who used to get services in 3632, in for example out-of-state settings, do not get them anymore and they are turning up with acute needs in our community. So we are trying to be as active as we can via in Sacramento to make sure that the

education system does the right thing.

Q: I am with part of Project ABC, which focuses on children 0 to 5. I thank you for being here and for sharing all of that amazing work that you have done. After hearing you and your stressing of the housing of the homeless that you created for those chronically homeless over a year, how about those families that have children 0 to 5? If they have to be homeless for a year, what is the trauma that would be caused to a family when they have to be homeless for a year before getting housing?

Q: We work with that. We see it on a daily basis in SPA 8. We have a lot of families that are homeless, with children 0 to 5, not finding homes. Especially now, working with the children, more children, the gentleman before was also stressing about high school kids being kicked out of the high school. Well, there are more children being kicked out of the preschool than high school. We have more, over three million children 0-to-3 in California. We just have to remember we were all children at one point, so let us make a difference. We have so much knowledge in this room. Let us continue the great work. Thank you.

Q: I am with the Mental Health Services Commission and just newly appointed to the Mental Health Commission, so I am really glad to finally have an opportunity to see all three departments coming together to discuss this issue. There has certainly been a lot of tension. I have had the opportunity to really follow the changes that happened in San Francisco over the years. I know the process there, and as it happens here, it is very different. So thank you for initiating the conversation. It was something that was already happening. It certainly is different from San Francisco, as you can tell.

I am not at all financially involved with anything here. I am a person with lived experience. I have been a client of DMH for 15 years. I have 40 years of experience with my disability so have I have a significant amount of smart knowledge that I think, like many of us, has kind of accrued over time. I also have really horrible bedside manners sometimes: I say what comes to my mind. I think that perhaps that sometimes can really alienate people.

I feel perhaps that that is perhaps what is happening here. I think the conversation for the integration of services is so important, for all of us, for me as a person that utilizes all of your services. I think, overall, I have benefitted more, if anything, from what the Department of Mental Health has to offer. As an LGBT person from the Native American community, I do not think I have ever had the opportunity to really utilize the other departments like I have the Department of Mental Health. They put up with me having a complex array of needs. I am really glad to have the opportunity for you to learn from them as they from you. Moving forward, if this were to happen, do you think perhaps the best option would be, if there is the creation of this health agency, whoever is going to manage it, possibly eliminate the three of you as a possibility of running for that position, to just kind of clear the air and kind of move forward? [Provokes audible laughter.] Is that something that could possibly just work on? I mean, just really looking, you know, justly, so we can have some resolution and we have no fear that there is going to be a conflict of interest from each one of you?

Q: First, I am a consumer and I go to [inaudible] Central and I volunteer at DMH under Helena. I am the Vice President of the Latino Coalition. DMH works. If it was not for DMH services and all of their teachings, I would not be here. I am a person with lived experience. I have lived in Skid Row. But I also live in the South Central area, yet I do not see you speak about that area and what you are going to do with the homeless that are sleeping under the bridges in that area. Are you going to create housing for people just in one area?

	Q: There was a call from the Clearing House in Pennsylvania on Monday and one of things they talked about was called Forensic Certified Peer Specialist trainings. Is this different from the certified peer specialist trainings that are going on? This is for people who are in the jails. They are using people who have been in jail to be providers. **DR. KATZ**: I think peers would be great. Yes, we want to bring housing into South Los Angeles. Actually, a lot of the 600 units are actually South Los Angeles. That is where we put the largest number of units so far. On the question of who runs the agency, I mean, that is a Board question. I think the Board is going to make that decision after they decide whether or not to do it. The only thing I would say is, because this comes up, I am personally not more committed to health services. I do not personally think of the world that way. I think of the people that I see who come into an East L.A. Urgent Care or who get hospitalized and have needs. Some of their needs are physical health, some are mental health, and some are substance abuse needs. It is my job to take care of them and I am not more in favor of substance abuse, or more in favor of traditional public health, or more in favor of mental health, or more in favor of health services. I do not view the world that way; that is not my vision. My vision is that you start with what somebody needs and you try to provide that to them with the best of your ability. **CINDY**: I want to say thank you for inviting me today to be part of this discussion. I really appreciate the wisdom in this room. Thank you.
Item 2: Department of Mental Health Updates and Discussion	As you know, there is a lot going on and I will share what we are envisioning as the three top priorities for the Department as a part of the planning process that gets developed for the new resources that may be coming through the Mental Health Services Act. You know there are new resources coming. Some of those resources will be CSS and some of it will be PEI ongoing, but some of it will be one-time funding because of the way funds spike. So we are going to be working with you to develop a plan and that process is beginning. However, in our discussion with the Board offices we are focusing on three priorities. The first of these priorities is 'diversion' because I think everybody believes that for those who can be diverted from the jail system into treatment, everybody wins when that happens. We are looking at doing all sorts of investments across-the-board, from pre-booking diversion to better after-care as a way of doing that. So it is not merely responding to Jackie Lacy's Task Force (which many of you also participate on) but also moving forward where we can in every possible way to advance the diversion agenda. The second priority is this issue of homelessness that came up today. Our proposal will be that we reinvigorate the Housing Trust Fund group by making a substantial use of the one-time CSS for that purpose, i.e., the housing effort, whether it is for the construction side or the services side or the support side. It is about the entire spectrum, not just one part of it. It is an investment we will mutually try to create a consensus around. The third area that is going to be Transition Age Youth because that is an area where our services are the youngest and the area where we believe we have the most strategic opportunity to make change. For example, in the substance abuse arena, Transition Age Youth is where a diversion into either the substance abuse treatment system or the mental health treatment makes the least sense. The literature is pretty clear that for Transition Age Youth co-occurring disorders is so frequent that you should really think of that as the same disease with differing

manifestations rather than two separate illnesses. So I think that focus on Transition Age Youth and all of the things that emanate from that will give us also some insights into how to better integrate services.

Those are the three major priorities. We are also going to look at trying to take steps to right size the unintended consequences of transformation both for the community agencies and directly operated programs. In other words, as you all know, in the 'transformation' process we ended up doing things that we had to do to preserve services in the best possible way and maybe it is time to look at those again to see if some of the things funded through PEI are better funded through CSS. If we do that, maybe we should look at our PEI activities in a comprehensive, population-based prevention program that is less tied to Evidence Based Practices as a prevention strategy and more tied to community investments.

Those are the broad themes we will be engaging on for the planning process and the conversations we are beginning to have with Board offices around those themes.

Q: I am hearing that there may also be some MHSA funding available from the state level to address health disparities. Do you know anything about that or has there been any sort of discussions about that at all? I just heard it from somebody in passing so that is why I am trying to validate it if it is a rumor or is there some truth to it.

Response: I have not heard that specific thing, but I have heard other ones. The area where there may be some use for us is the five percent of MHSA that was used for statewide purposes. If it confined to this five-percent, I think there may be some development.

Q: In addition to the MHSA increase in dollars there are also Trust Fund growth dollars that will be available. Is that correct? If so, what is the thinking about how to expand services with those dollars?

Response: The resources available through the 1991 Realignment have grown but not substantially. As you know, Realignment can be used for services in locked settings, IMDs, hospitals and so forth. It is the area where we have the least amount of resources. So those funds will be pretty much eaten up.

Q: How about the new Realignment, though?

Response: So with the new Realignment, there is not a significant baseline growth; but there is agreement is obtaining reimbursement for EPSDT for children's services next year. If we spend more, we will get more. There was some skepticism locally as to whether we would actually get the reimbursed, but we have gotten reimbursed. What that really means is that it frees up our planning for the use of EPSDT children's services. We have already begun the process of looking at where we need to expand services for kids using those EPSDT funds, including Wraparound services on one end to services for the less seriously ill, on the other. That is also taking place. In that arena of opportunities to services EPSDT kids, we have good news in terms of growth, both for directly operated programs and for community agencies.

Q: What can the DMH to do to help people understand co-occurring disorders better within each provider's agency and obtain better training? I feel we need that on the ground level and in the neighborhoods, too.

	Response: As you know, we have been providing training on substance abuse through UCLA, focused on motivational interviewing, seeking safety, and other EBPs to all providers. We continue to push that. We also have the Co-Occurring Conference coming in October, which will be the venue for thinking carefully about how we put this new benefit in place when the resource is available to put in place. **Q:** How would you work with this new agency if it does happen? Dr. Katz did not really answer my question in terms of how you guys would work together. **Response:** I am hoping that, agency or no agency, this new benefit is going to be a huge game changer for everything that most County departments do. For example, imagine if you have had a substance abuse treatment available and that you do not have to get arrested to access it. You have detox, you have residential, you have intensive outpatient, you have sober living—that is that needed as an entitlement. If that becomes available, think of all the child welfare that we will not have when that system is operational. I believe that in terms of ways that we can save money for the system and other systems, this substance abuse benefit—when it actually gets real and is in place—it will allow us to do a better job. **Comment:** I think that before it is put in place, it would be good to start building that foundation so that when the benefit starts there is already a foundation in terms of strategy. Response. Yes. We made the suggestion that we pre-invest in those kinds of services using the diversion money that the Board allocated: they allocated $30 million toward diversion. We put that forth the idea that we invest in creating those kinds of programs on the ground. It could be like one-time funding because when the benefit actually becomes available then the federal and the state funds can pay for that. **Q:** Did I hear you say you we got 'reimbursed'? **Response:** For the EPSDT, we spent more than our allocation but then we got the money we spent. So the State kept its promise. **Comment:** I just want to be sure about what you said because I remember years ago we were supposed to be getting reimbursed but did not. **Response:** That is a different kind of reimbursement that we still have not gotten. We have not gotten the AB 3632 reimbursements. The good news is that the Governor paid back $788 million in this budget process. So the County got a chunk of that. It does not matter to us because even though the County was not reimbursed initially, the CEO reimbursed DMH. So DMH already got paid. **Q:** Do you know if the waiver includes TAY? Or is it adults only? **Response:** The waiver refers to a Medicaid entitlement for anybody that has Medicaid. Like EPSDT, it should include substance abuse services. We have not understood why it had not included the benefit. So now it will.
Item 3: State	Updates will be provided via email.

Updates	
Item 4: MHSA Updates	Updates will be provided via email.
Public Comments	**Comment:** The 14th Annual Conference on Mental Health and Spirituality is going to take place on May 28, 2015, 'The Journey Called Life,' to be held at the Los Angeles Convention Center. We have family and consumer scholarships available, allowing families and consumers to attend free of charge. I also have the application here. **Comment:** The Health Education Network provides training on forensic peer mentoring. There is also a conference put on by the Mental Health Association in Pennsylvania from June 22 through 24, 2015. **Comment:** I just want to announce that the Mental Health Commission meeting will be next Thursday, May 28, 2015. We are starting at 9:00 in the morning. We will be meeting in this conference room. Following the Mental Health Commission meeting, Dr. Katz will be at our meeting; so if you did not hear enough today you can come back and hear some more. Following the regular meeting of the Mental Health Commission meeting we will be having the Public Hearing on the MHSA Annual Update. It conflicts with the Mental Health and Spirituality Conference, but we had our date first. [Laughter]