COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, February 18, 2015
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90026

Reasons for Meeting

1. Provide feedback to Board motion to consolidate various health departments.
2. Solicit feedback on refinements to Innovation 2 strategies and Implementation recommendations.

Board Consolidation Motion

Dr. Robin Kay: I just wanted to provide you with a little history and a little chronology and that'll take us right up to today and the work that we're going to do together. Many of you were here last time the SLT met. You contemplated and considered a number of principles at that point related and I'll come back to that in a minute. To the Board's proposed consolidation of the 3 health related departments; department of health services, department of mental health and department of public health.

But I wanted, this time, to take us back a little bit further and just give you some history and context. The department of mental health was established in 1960 as an independent department. And we functioned that way until 1972. In 1972 the board of supervisors was facing a pretty big crisis in that health department related to the operation of hospitals. At the same time the Short Doyle Act was passed and there was an infusion in California of federal dollars for mental health services.

I'm obviously giving you the Reader's Digest version of what went on. But to make a long story short the board, at that time, did what the board should do and that was to contemplate whether or not it would be prudent for the department of mental health and the department of health services to merge. At the time, 1972, they concluded that it would be a good idea, mostly because it was viewed, at the time, from the documents that we found in the archives, as a way of helping to sure up the hospital based programs in DHS.

A couple of things happened between 1972 and 1978 including the inability to access some of those funds for the DHS financial difficulties and also the erosion of mental health services at that time. In 1978 the board concluded that the merger really was not a success and they wanted to separate the 2 departments. DMH became a department again, an independent department.

Nevertheless, the question of, "What is the most efficient, economical, and best way to deliver services?" is something that the board of supervisors does and should contemplate from time to time. In 2004 - 2005 the civil grand jury asked the same question that came up again, "What's the best way for the county to deliver health related, mental health, and primary care services?" At that time the civil grand jury concluded that a merger was not really a good option because the populations served were different. The missions of the 2 departments were different. The cultures of the organizations were different.

But it's an issue that does and should come up periodically because the board should always be asking, "What's the most economical, effective, efficient, best way to serve clients?" Those of you that are from organizations know that we do this all of the time. We look at our own organizational structures and we ask ourselves, "Is the way we're organized the best way for us to support the mission of DMH, or Gateways or PACS or Share, or SAPC–", that's part of the work that we do.

It's within that context that the board, on January 13th, past a motion by Supervisor Antonovich, that approved, in concept, the consolidation of DHS, DMH, and public health. Initially, the motion read as an agency under DHS. Then the motion was amended, recognizing that agency structure might be a more appropriate structure concept, which would have, as we understand it, an agency director, and then the 3 departments, DHS, DMH, and public health, under an overarching agency; and directed the CEO to come back with a report on an analysis of the advantage and disadvantages of such a consolidation.

That takes us pretty much up to the present. You know that the following week the SLT met and this group developed, as we do, it's a tradition in SLT, we do it for budget planning, principles; we start with principles. You start with principles. We do it for budget planning which is a very inclusive and transparent process. Every big issue begins with principles. When you contemplated and approved a set of principles last month, Larry Liu from the mental health commission was here representing the commission and the following week the commission took those principles, as an example, and then made some modifications because the commission wanted to have their set of principles, very similar to what was approved by the SLT.

And so those principles were submitted to the board. I understand that the public health commission also had a set of principles, again, a different language but primarily the same concepts. Those principles, people have asked, "What are they for?" They serve as a touchstone, a way of measuring recommendations and implementation against the principles that you all and we all hold dear. I won't go through principles because a lot of that work was done last time.

One of the things that the CEO was charged with doing was getting broad feedback from many entities about the benefits and risks of a consolidated agency model. That's what Dr. Ghaly is here to do today. Some of you have participated in other stakeholder meetings. We've had quite a number of them; joint commissions, the mental health commission and the public health commission met together, the SAACs met and provided input, the hospital association has met as a stakeholder group, NAMI has met as a stakeholder group, the client coalitions have met, the underrepresented--I could go on and on.

There have been a number of stakeholder meetings. I will say that within DMH, because our staff are also stakeholders, we've had quite a number of discussions in programs. Cathy Warner is here, she has led a number of discussions within the service areas 7 and 8 programs for DMH. We've had discussions in the District Chief's meeting, in EMT, etc. I will say that the department last night provided to Dr. Ghaly a summary of the internal DMH stakeholder conversations.

We're here today to another stakeholder discussion. Dr. Ghaly will go over them and you've got a copy of the questions to be answered. It's really important that all of our voices be heard. Nobody knows the functioning of the department, in particular, MHSA, the way that you all do,

and the department as a whole. So you're in a perfect position to be able to imagine what might be beneficial if an agency structure were to be established and what might be perilous if an agency structure was established.

The discussions will focus on 2 main areas: "Is there a possible enhancement to service delivery?" and "What are the administrative changes that might be made to support an agency? So slightly different issues, we're delighted that Dr. Ghaly has joined us, delighted that you're here

to provide your input. It will become part of the final report to the board, which is coming up soon. With that I'm going to turn the microphone over to Dr. Ghaly who is currently serving, on a temporary basis, on loan from DHS to the CEO to conduct this planning process.

Dr. Ghaly's Reponse: My role here is really to listen. I will speak very briefly. I will cover the overview. But the board has asked to get broad input. That's what we're here to do. I'm here to listen to your comments. I'm happy to answer questions. If people have specific questions I will do my best to answer them. But mostly I really want to listen to you and listen to your input and your ideas, concerns, and suggestions, about what you'd like to see happen, what you're worried about, and just your thoughts on this agency motion in general.

Robin provided the background. I would add the obvious, which is that the way this came about did not create an atmosphere of trust among many different stakeholder groups, constituents, among patients, clients, customers, and different advocacy organizations. I just want, before we go any further, to openly acknowledge that. I think that people have different opinions about how the board did it, about the language that was used in the board motion, the language of the term 'consolidation', which is not one that I am using.

But we are where we are. I think the role now is to try to work, over time, to rebuilding that trust; trust in the process and trust ultimately in the outcome. So I just want to state upfront that I acknowledge and understand that. My role here is, again, to be open and listen to you. I will work to help build that trust over time.

Everyone I've spoken with, while there are very different perspectives on this topic, every single person I've spoken with at some point in the conversation says, "We all want the same thing." I do think that all of the different groups want the same thing. They want the best outcome for the residents of LA County, whether it's patients, clients, consumers, whether it's for certain programs, regulatory and policy making activities, everyone wants the best outcome. So I think it's helpful to start at the place where we do have a shared goal and shared vision. That's just to acknowledge that everyone is thinking the same thing despite the fact that there may be different opinions about what best way there is to get there.

With respect to the agency, in particular, the goal is to be able to improve services. I use the word 'services' very broadly. I won't try to keep repeating the language but when I say the word 'services' I do mean the full spectrum of what's provided within the 3 departments. Obviously, they have a different mix of services and a different mix of activities in each of the 3 departments. Public health takes on a much stronger policy making and regulatory role though each of the other 2 departments, DHS and DMH, also have some roles in policy and regulatory activities. There is a direct clinical services component. There are programmatic activities. There is population, health and preventive health activities. I do mean the full spectrum of those services.

A lot of people have said, "Well if it's not broken, don't fix it," or, "I have received wonderful services from" whichever department that might be, "so please leave it alone." As many times as I've heard that I've also heard others say, "Well it's working for these people over here but it's not working for these people over here. So what can be done to do better? I think that's ultimately what's behind this decision by the board and the discussion at the board is, "What can be done to help make sure that all of the residents in LA County have as high quality of services broadly defined as possible?"

I also want to acknowledge, obviously, that there is a lot of work of integration that is ongoing. There is a lot of good work that the DMH has done in collaboration with other county departments, including DPH and DHS, but also with other county departments, with sheriff's department, with probation, with DCFS, with CCS, and with a lot of different organizations. In no way should this be a reflection of the fact that there is not good work already being done. The question is, moving forward, "What's the best way to get to the next level of what is possible?"

Some people have asked for specific examples of what the goal is or what the opportunities are under an agency model. I don't want to talk about those too much here today. I'm not here to sell you on anything. I'm not here to convince you that this is the right answer or the wrong answer. I'll share just a few thoughts about what I've heard from other individuals or same of the examples I've brought up in some of the other meetings. But I give them just as starters for discussion and would love people's reactions to those or suggestions of other opportunities that they think the agency might create.

A lot of people have talked about the ability to better coordinate care and do integrated case management and joint care management plans at the level of primary care, community mental health, substance abuse services, of the need to work on better co-location, whether it's physical or virtual co-location, of the fact that there is a lot of times, as we all know, it's the social determinants of health that are holding our patients and clients back and that by better addressing those social determinants of health, addressing issues of poverty, homelessness, unemployment, lack of living in a safe and healthy community, that those issues are ultimately what is going to improve the health and well-being of patients, regardless of which department they receive those health related services in.

There has been discussion about being able to streamline access to care, on working on IT systems, registration processes, and financial screening processes. Depending on the context where it's taken absolutely means the full spectrum of providers that are involved in LA County. It's not meant to mean just the directly operated clinics within either DMH, DHS or DPH. Obviously, each of the 3 departments has a very broad network of contracted providers who provide direct services but who also provide other activities for the departments. I think it's important to make sure that the agency maintains that broad focus on services rather than simply focusing on only the directly operated portions of the network.

There has been a lot of talk about integrating population health and community based interventions better into mental health and primary care settings; but how you could inform population health activities with what's going on in the ground in the clinical setting and how you could take those population health activities and integrate them in, work on obesity prevention, safe communities, and again, that would be done across the full spectrum of the patients and clients that are ultimately served by the county, and not, just again, those in the directly operated clinics and hospitals within DHS or within DMH.

Some people have raised on the public health side the possibility of better responding to public health threats. People have talked a lot about the recovery model. That is such a strong component and a very positive characteristic of the community mental health system. Certainly I've heard concerns that there will be a medicalization of the mental health model, that if DMH and DHS work more closely together that it will lead to the over medicalization of mental health care, that there will be increased prescribing and increased focus on that medical model. I am happy to talk about that concern if there are any. I would offer though that I've heard equally strongly that there is an opportunity rather than

to lead away of the medicalization of the physical health model and allow the recovery model to be able to be better integrated into that physical model.

I'm a primary care physician. I'm a physician in urgent care. I know very well that when patients come into a clinic oftentimes they don't need a lab test and they don't need an MRI. They don't need yet another prescription. What they need is someone that's working on their social supports, working on their broader community engagement, and on the number of factors that affect their life and health. I think there is a huge number of assets that are in the recovery model that is so strong in the DMH and there is a lot that everyone could learn from that.

I won't go on too much about the opportunities. Again, I want to hear from everybody here what they think are the opportunities and that risks. I will say on the subject of risks that I've heard several. I'll run through the list here just so people understand, I would say, very broad categories of what I've heard, I won't get into the nuances of each, but I want to be open with what I think of as the major categories that I've heard.

Those are first and foremost that Robin eluded in her introduction is that history will repeat itself. The history of the mergers, the budget cuts in the late 1990's and the early 2000's in public health, will repeat itself. Some, either assumption or expectation, that the board might be doing this for financial gain, to have cost cutting initiatives, the tendency toward crises or emergencies then toward high cost problems in the physical health system might lead ultimately to the reduction of resources that are available in either the public health system or the mental health system. I want to make very clear that, as proposed by the board, this is not a merger. I don't think the word merger is what applies to the agency description.

An agency, in organizational and in government governance, is the creation of an entity where then the 3 departments would report to that agency but maintain the full structure of those reporting departments, full budget and full appropriation of authority within the departments and maintain the department head. The board of supervisors has the full authority to be able to set the appropriation breach department. That authority, I would add, is not able to be delegated. The agency director would not have the authority to move money from one department to another.

So you couldn't say, for example, have a fiscal crisis in DHS or in one of the other departments, and move money from mental health or another department over to the department where there is a fiscal crisis. The board could do that. The board could do that today. There is nothing that would prevent the board from making that decision today if one of the departments even outside of the health sphere had a fiscal crisis. But there is nothing about the creation of an agency that would change that. Still, I think that there is a very real concern that somehow,

in part because of the lack of transparency into the budget process in the county system, that there would eventually be a risk of service cuts and a risk of the budget being put at risk for critical population health and mental health services.

I've heard a lot about people being concerned that the departments would become too insular, would not have the full breadth and scope on their full mission. Public health serves all 10 million residents in LA County. Mental health, in many ways, serves the same with its prevention

activities, but also does focus on a subset of those patients and clients through direct services. DHS has some activities that affect the broad population but also focuses very specifically on the 800,000 patients that it serves through direct or contracted services.

I've heard that people are worried only the areas of overlap is where the agency would focus and that would be done at the expense of all of the other things the departments do; all of the other programs and activities, that regulatory activities and the DPH would take a hit, that community mental health to the extent that there is not overlap with the physical health system, would not be prioritized. I think there are lots of different ways that this idea has come up. It's an important one to think about. If an agency is created what is the best way to make sure that the departments do maintain their full breadth of mission? Obviously those missions are critical to ultimately improving the health and well-being of Los Angeles county residents.

I would say the third general category of risks heard is about bureaucracy, additional layers of government, concern that the agency would be a costly endeavor that money would have to be put into the agency, and then the question about where that money would come from, because certainly the board hasn't necessarily volunteered additional funds to do this. Would the funds come from the departments themselves? Would additional net county costs be put into the departments and into the agency? How many layers would be present in the agency?

I think it's a great set of questions and certainly one that should be taken into account when proposing a structure for the agency. What I've understood in discussions broadly with a number of different individuals is that the intention is to have a very lean agency structure without additional levels. There is no added budget that is being considered for the creation of an agency. The board has been very clear that they don't intend to add additional items or an additional budget to create this.

So then the question is, "How do you create a very lean agency that relies on the strengths on the individuals and departments within each department to be able to build up agency functions to the extent agency functions should even exist?" Very clearly, I think what I've heard from pretty much everybody is that people should be very slow to place anything at an agency level and to create an agency function. That would need to be done carefully with a lot of study and overtime and careful not to disrupt critical services. You can't simply move a finance department out of a department and into an agency level without disrupting billing, charge, claiming, cost reports, financial documents that are critical to departmental operations. The same can be said for a number of different administrative functions such as HR, contracting, and others.

I have heard from suggestions from certain people about what they would like to see in an agency level. I'd be happy to talk about that, but more, again, I'd like to hear that from you here. I would say that the general theme is that people might be interested in more strategic

functions at an agency level, someone that's helping the department make decisions that are well aligned and coordinated to the extent that it's in the best interest of services but that it wouldn't be the full scale move of certain administrative functions to the agency level.

I spoke briefly about it and I won't talk more but I very much heard the risk of the medicalization of the mental health model. Again, I think that really is an opportunity but also a risk and a risk that would need to be very cautious to make sure that it doesn't happen.

I've heard particularly from private contractors and also from private nonprofit organizations that they're concerned about their future under an agency model. They describe having very strongly relationships with certain department leadership including this department, the DMH. They talk about being worried, not so much that their services would be cut, but that their contracts would be cut or that their existing relationships with the department would change, if there was new leadership in place who didn't necessarily understand the history, understand their contributions, or have the same vision about what the shape of things would be moving forward.

I've heard concerns about cultural friction and a concern that the unique cultures and the strengths of those unique cultures within the different departments would be diluted or changed in a negative way over time as a result of the agency. I think absolutely there are tremendous strengths of each of the three departments from a cultural standpoint. I won't go into detail but I think particularly within the mental health department there is a strong culture of community engagement, stakeholder participation, focus on recovery model, focus on as the plaque says, "hope, wellness, and recovery." I think there are multiple aspects of the culture of DMH that are strong and should be preserved. The same could be said of DPH and DHS. The question is whether or not an agency would change that, whether or not there are opportunities to allow the departments to learn from what is best in the other without losing what is best in the other.

Finally, I've heard concerns that the process of planning for an agency will distract from the good work of integration which is ultimately what is needed to improve services. People are worried about long, drawn out planning phases where they go to multiple different meetings and processes where they have to think about a 1 year plan to be able to move 1 tiny unit over to another area. I think this overlaps a lot with the issue bureaucracy and a concern about administrative layers. People want to do the work that they do because they want clients and patients to get better services not because they want to sit in a room full of meetings talking about what should move on an org chart.

I put those forward as a very high level summary of concerns. I know I've gone through them very quickly and I've glossed over a lot of the nuances of them. But I wanted to be open about them.

Moving forward, just a note about the process and then we'll open it up for discussion. The board asked for a 60 day report back. That 60 days will ends March 13th. The process of developing a report obviously requires a lot of stakeholder input before the report is developed. To this point I have not written anything. I started drafting an introduction this weekend but literally that's it. There is no org chart on paper. There is no written document about what this looks like. If anyone has seen anything it wasn't developed by me.

So the process of getting stakeholder input is very important and should absolutely be done before a report is written. With that said, people have an understandable desire and right to respond to a document after it's written but before it's final. So because of that the report will be released to the public, including the board, on March 13th. It will be released as a draft. Then we'll open up a 30 day comment period where I

would invite and welcome any and all stakeholder input. I promise you the report will not be right the first time and it will need your thoughts, ideas, and suggestions about how to strengthen it. I would welcome that input in written form and then also in oral form. We'll have several public convening, dates, and times still to be scheduled where we would invite different stakeholders to come and share their perspectives.

At the end of 30 days we will modify the report. The written stakeholder comments that we received from the public will be included with the final version of the report as a full appendix so that people can see the full color of what was written in the report and encourage open transparency and communication. Then the report within 30 days of that will be delivered to the board as a final copy. That will be no later than May 12th. Then the board could take whatever action they would take.

Your feedback is very important. I know there are a lot of concerns. There is a lot of fear and anxiety. There may be a lot of questions. There may be confusion. Certainly, if I can help to clarify confusion I would love to do that. I will try to answer questions but mostly I am here to listen to you and listen to what you'd like to see happen, what you would not like to see happen and just have an open dialogue so thank you for letting me be here.

Comment: One of my major concerns from the law enforcement perspective is that the vast majority of the calls that we receive and manage are crisis related mental health calls along with public health issues. While we've had a very good working relationship with the DMH in developing strategies to combine our efforts to mitigate these types of calls for service and manage them we haven't received the same feedback when dealing with the psychiatric emergency departments in DHS. My concern is that there might be a trickle down or pollution of the culture of cooperation because of the perspective from the DHS side as opposed to the DMH side.

Dr. Ghaly's Response: I will not try to address every comment. I will just say that certainly your perspective is very valid to the extent that certain things have worked with DMH. I see no reason why that wouldn't be able to continue under an agency. I think the Psych ER issue is very complicated. I know it very well. There is a lot of different factors that play on both the DHS and the DMH side. But certainly the goal would be to work and to continue working very productively.

Comment: My concern is that historically the DMH or mental health issues have been looked at as secondary issues compared to the physical and the DPH and the public services at the health services department. I'm afraid that with this integration that will continue and then other 2 departments will take over rather than look more closely and give precedent to the mental health issues.

Comment: I think that it looks like there could be a lot of advantages. Everybody's integrating at the moment, blah, blah, blah. The difficulties that I see are more practical ones, for example, housing. What we've seen in housing is that when there is an agency that does any sort of housing there is stigma against mental health consumers. They allowed the mental health consumers to get evicted for erratic behavior that easily be gotten under control. What we've seen in the past is that when there is money that is supposed to be for all types of housing, including mental health, that the mental health consumers don't get the housing. That's a really big concern. It's easier to deal with somebody that I don't have stigma and discrimination against then it is to deal with somebody that I do.

The other part of that is that the recovery model may be alive and well in DMH but it is certainly not throughout DMH. We fight every day with including the recovery aspects against what Medi-Cal is willing to pay for; this idea that, all of a sudden, getting a bigger Medi-Cal contingency that we're not going to be able to keep the recovery aspects going. When we look at both health and mental health care we find out that we have a new mega study done that shows that 40% of health and mental health wellness comes from a lack of social isolation. So we really do need to be working on these issues. Yet when it comes down to it it's much easier to do Medi-Cal and to measure how many units of service were done than to use some of the newer measurements for, "How do we get people a sense of community?" "How do we get people not to be isolated?"

I have to put in a plug for self help support groups that are totally under used, almost free, and the health people aren't using them practically at all. The mental health people still want to have a paid person in each group even though the evidence based best practice is not having paid people in those groups. I think we've got to look at how we're going to make this happen in a practical way.

Comment: From the substance use disorder perspective I just wanted to emphasize that in the context of other co morbid physical and mental health conditions we still realize that substance use disorder is a discreet, chronic, brain disease and needs to be treated as such, in the context, and that we don't let it become a subset of mental health or physical health.

Q: There was an original comment, and, again, there is certainly a concern about the atmosphere of trust and why did it happen this way. I have not heard why it did happen this way. In other words, what, all of a sudden, created this push by health services to consolidate? Where did that come from? As I said at the hearings, the public health and health committees didn't come from mental health. It didn't come from public health. It obviously came from health services.

The second part of that question is, "What has health services done over the last 4 years to improve integrated health and mental health care?"

Dr. Ghaly's Response: In my role I'm currently assigned to the CEO. I don't see that it's appropriate for me to respond on behalf of DHS. I did used to work for DHS. That is my permanent role. With that said, that's not my current role. So I would welcome you asking that question to Dr. Katz or to his staff who would be best positioned to respond to it. I say that in all fairness. It wouldn't be fair for me to only speak for DHS but then not to speak for the other 2 departments.

In terms of how this came about I'll tell you what is also in the LA Times. The memo is on the health integration website if you haven't seen it. Again, I would encourage you to ask that same question to the board and to Dr. Katz, if you would like, because those are the individuals that were involved.

There was a closed session in early January related to the selection of a director for the DPH. In that context they asked Dr. Katz to come into the meeting. I was not in the room. It's also hearsay after that. I wasn't there to listen to the actual conversation. But during the course of the conversation the board asked Dr. Katz to write a memo, which I said is on the website. The memo written was in response to that board

request about creating an agency. The discussion at that time was [inaudible]. Then they met again in a follow up closed session to look at the memo and decided, again, I wasn't in the room, to put it on the board agenda.

I think the question really needs to be presented to the board though. I would encourage you to speak with them and certainly with Dr. Katz, if you would like.

Comment: We would like to see him here.

Dr. Ghaly's Response: I think that would be a great idea if you invited him.

Comment: Again, it sounded, from what I understand, maybe correct me if I'm wrong, the board asked Dr. Katz to write a memo after he suggested the idea of the integration. Is that your understanding?

Dr. Ghaly's Response: I can only say what my understanding is. Other than that I feel like the people that are involved in the actual meetings would need to speak for themselves. They asked him to come into the closed session. They asked him to write a memo. He wrote the memo in response to that request. I think having you speak for him here directly may be helpful. I don't want to impose on your meeting. It's your meeting and your decision. But I would encourage you to speak with him or the board about it.

Q: One separate thing on the process which is, overall, I said this earlier, certainly the way this came about is concerning. There is no doubt that there are certainly serious trust issues. At the same time the one thing that I said earlier that I appreciate is that the process itself of having all of the stakeholder meetings and then a preliminary report and an opportunity to comment. I think that's a good process so I want to acknowledge that, completely objectively.

The one thing that I see here on the list of key questions that I didn't understand from the mental health and public health hearing is that there is a question now about, "Other than a model of an agency director and 3 distinct reporting departments what additional models should be considered?" Was that added? Or was that always on here? I understood and heard, and maybe I misunderstood, that really the main focus of the report was going to be on this agency model and there was going to be very little discussion of these other models that would be considered.

Dr. Ghaly's Response: That's correct. The report asked for 5 things: the opportunities and benefits of the agency model, the drawbacks, the proposed structure, and the context they're referring to the agency model, the implementation steps and timeframe for achievement of what they call the consolidation, which is, again, not the word I'm using. These questions don't directly mirror what's in the board report. We've added the question about alternatives just because it's come up so much.

The report will not include a very detailed, fleshing out of what all of those various different possibilities look like but because it's come up in so many different contexts of people saying, "Well I don't want this, I would like this", or "I want to see these departments or these entities"

that we felt like it was fair in the spirit of openness and transparency to put that question out there so people can offer an opinion in other venues if they want to. There will be a section of the report that, at a very high level, lists those different ideas that will come out.

Q: They'll just list them?

Dr. Ghaly's Response: Well I haven't written it yet so I can't tell you exactly what it's going to say. But it's going to list, generally speaking, the ideas that people have said.

Q: I think that my reflection of what I would say having conducted the commission hearing was, and you heard it particularly from consumers, a lot of distrust, a lack of confidence, a feeling of lack of transparency, and they still ask the questions and I don't know when they're going to get their answers about, "Why?", some of the things that Bruce voiced. You've done a great job of identifying and summarizing a lot of the input you've received but I don't see responses to it. It's just a recitation of all of these things. Even if you're going to talk about other models--you put in a question in there but you did it only for the audience and not for the sake of the sake of the report, talking about #3.

I've heard people wanting to talk about additional models, wanting to know the advantages and disadvantages of these other models as opposed to the proposed agency model. I don't hear that conversation being invited. I don't hear that, even from your statement, do you do some assessment of that? That's not there. I think it's the lack of how all of the input is going to be evaluated and considered and thoughtfully addressed in terms of how these things will be accomplished or incorporated I haven't heard. I don't hear who's going to be involved in that discussion. You're hearing from everybody but I don't know hear, from the meetings that I've attended; a back and forth to really review those things and hear from people why they think this would be a better model.

Particularly, I think DHS--you were talking about the medicalization model and maybe there could be improvements on it. Well why isn't DHS working on it? Does it need an agency, another boss, another layer to tell them to do the right thing?

Dr. Ghaly's Response: I'm not here to speak on behalf of the department. I will say that there are a lot of things that DHS is doing to move away from the medicalization model but it's not my place to try and advertise those or defend DHS. On the alternative models the question is intentionally put here because it has come up so much and people asked for an opportunity to speak on that. It is as one, very small, way of encouraging discussion on that. It will be put, despite the fact that the board didn't specifically request for consideration of alternative models or alternative structures.

But I do intend to put in, again, not a dissertation on it, but some discussion on other ideas people have raised. I think in the spirit of transparency that's part of this more full discussion. Again, it is aimed at transparency.

Your other point just about the responses, my role is to gather the input, work collaboratively with the entities that were outlined in the board motion and then the departments, as well as the department of human resources and county counsel and CEO, as named in the motion, will have a chance to edit the document before it's released, just a draft to the public, and then we'll incorporate that input. It's, in part, because

people should have a chance to see how their input was put into a draft, why there is that 30 day comment period and why their written comments will be attached in full transparency to the actual final report of the document.

Q: I can understand a little bit how the agency might have an impact with health services, public health, and mental health but we have a lot of other partners that we're not talking about. We have probation, DCFS, there is housing, sheriffs, just a whole lot of partners. I don't understand the role that the agency would play in DMH's broad network of partnerships. I don't see how that's going to be helpful.

Dr. Ghaly's Response: This is another side of one of those risks that I mentioned. People have raised concerns that the agency would focus on just the areas where the 3 departments' together overlap or potentially 2 do at the expense of some of those broader partnerships or clients, patients, or programs. Certainly the other cross departmental relationships outside of the health related departments have been raised.

Q: The voice of families and consumers has to be heard so I'm going to give you a case. I'm an LCSW so I have do it. This is an FSP client. The family came to be under extreme duress, care giver burden. The adopted family, they had cultural bias, they were Spanish. She was indigent, Black, Puerto Rican, Spanish speaking, bilingual though.

We were engaged in legal services because she obviously was indigent. She had serious mental illness, chronic lifelong. The only place she didn't hear voices was in the Catholic Church, even with medications. She did not have substance abuse, thankfully. She did have a baby with DCFS. She had no housing. She did not qualify for GR because of her legal status. She was involved in mental health court. She was under court order for treatment. She was ordered for domestic violence classes as the perpetrator which was impossible to find. She was diabetic, obese, and insulin dependent and she wanted birth control. That's a brief summary.

The advantages of consolidation obviously would be with DHS to help me get diabetic medication for her and get her regular care for her diabetes and birth control and that did work with a lot of work. I didn't need public health at all. She didn't have substance so thankfully for that. We were involved also with DCFS court justice system and obviously the church because she showed up there a lot.

That's a case consult, where I think there are some definite advantages. The disadvantages, the only one I want to mention is that the consumer voice and the family voice is very small, even in DMH and even though we purport the recovery model I encountered, daily, people that do not understand what it feels like to have mental illness and do not understand the caregiver burden that is associated with mental illness that is serious, chronic, and lifelong.

On #3, the other model that I would like to purport is a grassroots model. Start with change at the bottom, turn the triangle upside down. Start the change at the bottom. Do case consultations and overlapping with my client and all of the other services that she needed and make it a little easier to get those health care services like birth control and those kind of things.

Lastly, I just want to address #7, the thoughts of implementation timeline. If we do turn this agency model upside down and start with a grassroots I think that time will show itself and that we won't really need a timeline.

Comment: The work that we have done in service area 2 in terms of integration, there has been some work between mental health and primary care, one of the stumbling blocks that we have found that a great deal of people in primary care don't really understand specialty mental health and feel like that they can handle those kinds of clients until they get to a crisis or suicidal client. Then they want us to take over. I think we're hopeful in this process that maybe some education can happen but we really want to protect our specialty mental health.

Q: Just echoing some of the sentiment around service integration and how that's been advantageous and also disadvantageous, particularly the DMH model as far as innovations. I think there have been successes but also challenges in that, so just really ensuring that the voice of the consumers, particularly from a mental health perspective, is definitely heard during this process.

Some comments in terms of some of the key questions for stakeholders under #4 and 5, as far as the centralized administration functions, I was wondering if you could comment, I know it's still in the preliminary stages, but we already deal with a lot of bureaucracy, as you know, just concerned about how further bureaucracy could impact delivery of services, even the basic process of billing or contract execution which could potentially delay services. I think that's always an ongoing constant issue that providers face and ultimately consumers are the ones that suffer from it.

Dr. Ghaly's Response: On your last point that's certainly something I've heard very clearly. I don't think anybody in this room wants more bureaucracy in the county. That's come through and, I think, very practically people raised issues of contracting, of procurements, supply chain issues, financing, billing, claims and making sure that an agency doesn't just create another layer of that, so that you have it in the department and you go to the agency level to do it all again. That would be a very bad outcome.

Q: I'm choosing to view this as an opportunity. One thing we do well and that I've been very hardened to be part of in this department is to participate in this body and be aligned with the recovery approach. You see before you a real partnership of people who are providing services, people who have "been there, done that", people who are caregivers, family members, consumers, and living proof of what we do works.

Before this I worked with DHS in a program that is now under DPH. The office of aids programs has gone through some changes. It was very informative to me. It was very inspiring to me be part of that, of what was really recovery based and very activist oriented approach to being involved in services. It's my hope that there will be some synergy and that what we do here will inform the other agencies and that is being taken into account, of course. We are all here at the behest of being in an advisory capacity to MHSA. So we will persist.

That leads me to a question. What other advisory bodies and entities have been consulted? We are a loud a rangy bunch here. I know you spoke to us last week about, as part of UREP, about our concerns for our underserved and underrepresented communities. But I'm just wondering what other, because I don't know everything that goes on in the county, entities or commissions, like the American Indian Commission, for instance.

We're a small community, the American Indian population, so we touch all parts of the system and we do it as best as we can. But we're somewhat disenfranchised and I know there are all sorts of underserved that have advisory bodies and commissions. To what end have they been contacted to weigh in and provide input? That includes the Gay and Lesbian community and the deaf and hard of hearing communities.

Dr. Ghaly's Response: I have some copies. There is a list of groups that we are proactively reaching out to that we've met with. Sometimes they're grouped together for a chance for multiple different groups to come together at the same time. Per their request, sometimes groups want an individual meeting. This group was developed with the feedback of the 3 department heads. We asked them to send to the CEO a list

of the stakeholder groups that they wanted the CEO to engage with. Also, some other groups have self-identified just by calling me or by, there is a place on the county CEO website, where you can ask to be included in the stakeholder process.

I'd be happy to accommodate any group that wanted to weigh in on this. So if some of the suggestions that you made in American Indian Commission or others, if they want to have a chance to engage you can either point them to existing mediums that are set up if they want to go or if they want to have a separate meeting I'm happy to do that. The website is a great place to do that. There is a place, I think its "Contact Us" where they can put in their request.

Q: What Mark referred to, for those in the SLT that weren't aware, we had a meeting with the cultural competency committee and UREP communities with Dr. Ghaly to give our testimony and feedback. Some of the issues that came up, I'll just summarize our concerns, that this kind of consolidation would result in higher percentages of disparity and also the issue of cultural competency of course is as important to all of us.

The API's presented and Dr. Hatanaka presented some research of the literature in terms of this kind of consolidation. I want to put in that we think it's important that the report have some references that show researched literature on this type of merger because he seemed to feel, from his research, that the success rate is pretty low.

I know that there are a number of work groups, about 17, going on now amongst the 3 major departments. I'd like to know how the information from those work groups will be incorporated into the report. My understanding is that a lot of it is a very detailed, administrative work that actually is "How to implement a consolidation" rather than discussion whether or not a consolidation is possible.

Dr. Ghaly's Response: There are 17 work groups. The stakeholder is someone--they have involvement from each of the 3 departments; the individuals that are involved in those groups were identified by the department leadership. There is a facilitator not from the department who is helping to guide people through the discussion. The discussion is about the 5 questions that the board asked for the response on opportunities, drawbacks, proposed structure, implementation steps and timeline.

The feedback from those groups, the facilitators are typing it up making sure that the group gets a chance to weigh in on it for accuracy. It will then be sent to me an incorporated into the document. Then, absolutely, that's again the purpose of that 30 day comment period to make sure that there weren't omissions, errors, or inappropriate statements made, that there can be opportunity to correct those.

Q: Does this Dr. Katz going to have anything to do this report?

Dr. Ghaly's Response: Dr. Katz is the head of the DHS. Each of the 3 heads of the departments will have a chance to read and edit the document before it is released to the public, Dr. Katz as well as Dr. Southard and Cindy Harding. When it's released to the public there will be broad stakeholder input and then again before the final document is completed the department heads, the 3 department heads including Dr.

Katz as well as the others, and then also county counsel in department of human resources and the CEO also will again review and edit the document before it's final.

Q: I just want to know what his role is [Dr. Katz].

Dr. Ghaly's Response: His role is the same as each of the other 2 department heads.

Q: I'm not going to repeat what we gave you because I felt it was well done by all of those involved in the cultural competency committee and all of the UREP groups but I'm going to reaffirm the issue of disparity and cultural competency. We clearly made it clear that cultural competency is not just a linguistic effectiveness, it's also about understanding the people and doing the right things and letting them have a say.

I'm going to reiterate, for the group, that this is just one body that this department has created a process that allows people to give input to changes and things that they are going to do before they do it. They've been very gracious in doing that. They don't do everything we want them to do but at least they're kind enough to hear it and we see that they do incorporate some of the things that we're suggesting, that they're capable of doing within the structure of their organization. I hope that in this reorganization whether it be at the top, in the middle, or at the bottom, that there is a process that continues to allow this voice to be heard and things to happen.

This department has done an outstanding job of going out and testing different models because I didn't hear about that in your comments. We need to take into account what they've learned, how they're doing it, and what all the contributors are saying about what we can do better. The third thing that I'm not hearing and that really concerns me is, "What kind of service model this entity is going to create?", especially at the crossroads and the points and services that a client needs crosses these intersections in the quadrant of services from health, mental health, and public health and even substance abuse, how that inner case management will work, what that will look like and the shared case documentation will look like? I'm not hearing about the practicality on the ground as to what that will look like. I'm very concerned that we're talking here but not talking about what the people will see.

Dr. Ghaly's Response: Certainly a lot of that work will happen over time, which is the work of the departments, agency, and the integration work. In a 60 day report back there is no feasibility. It wouldn't be realistic nor appropriate to try and outline how services are being fundamentally changed. That's not the purpose of the report.

Comment: As a county employee I'm going to remain agnostic about this whole proposal but I have been involved with the Katie A lawsuit for many years on the department's side. I do have concerns about this proposed change and our county's ability to meet the mental health needs of the children we serve. Some 85% of the children we serve in our department are screening positive for mental health needs. Under the Katie A settlement agreement we are approaching those families with the teaming approach that does require all professionals to sit down the family together to effect positive change to the extent that the models under which services in public health currently operate I just hope that we can figure out a way to continue moving toward our exit strategy on the Katie A lawsuit.

Q: What is that lawsuit?

A: It was a settlement agreement that was crafted in 2002 and finalized in 2003 in which Los Angeles County and the named defendants were children services, public health, I'm sorry, health services and probation agreed to make a reattempt to close MacLaren Children's Center, MacLaren Hall, improve mental health services to children, to have better stability in placement for kids, prevent kids from moving from placement to placement, deliver intensive home based services to families and therapeutic foster care, in a nutshell.

Q: Who were the plaintiffs?

A: The plaintiffs were a group of children at MacLaren Children's Center who are represented by a couple of law firms, Western Center for Poverty and Law, being principle.

Dr. Ghaly's response: I would say, in general, if the work of the department is great and if there is no benefit from greater collaboration or involvement by others it should just be left alone. I think everyone would agree that the agency shouldn't have any scope or desire to touch things that are working perfectly well.

Comment: I would like to reiterate that clients/consumers be a part of the stakeholders and a part of the decision making for this agency and that we not be left out. Also, I'd like to say again that everyone from top to the bottom needs to be trained, taking this on, about mental health. There is a lot of stigma around the board. This needs to be raised. Those are the 2 things I would like to point out.

Comment: The American Federation of state, county, and municipal employees is not yet taken a stance, yes or no on this, because we're interested to hear and give input. One of the things that you know already is that the people in this room and a lot more have worked long and hard over the last several years to improve and expand mental health services in Los Angeles County. Everything's a work in progress.

I think probably what a lot of us fear is that mental health become a stepchild to another department and sort of undermine all of the work that we've done. Even now in some of our integrated programs or co-located programs there are still struggles when we're working with other partners. Oftentimes mental health does still get steam rolled by those partners. It's our house. Well it really isn't anybody else's house. It's the county's house and the mental health mission needs to be carried forward no matter what the walls look like.

We have problems with our probation side. There are significant problems in the DMH, DHS collaboration programs. They are kind of a mess. We would just like to see that if this process goes forward as an agency that mental health be protected in that way and keep its strength and not be subsumed.

The second issue though, I know that this is more about service than money, or that's what's being said, but there could be an opportunity for efficiencies, and I see it, not necessarily in direct services but in what supports direct services, which is like the human resources piece. Each department now has its own human resources. Some, frankly, are done better than others, more professionally, more efficiently, just a lot

better. So perhaps we could look at, if we do go toward this integration, combining human resources and taking the best practices from who is doing it best and get rid of all of the junk.

Q: I still haven't heard what the advantage to the DMH there is in this process, how it will positively impact the DMH. Until I hear that it's kind of going in one ear and out the other.

The fact that #3 is only on here as a key question, and I very much appreciate that you added it as a key question, is pretty compelling and pretty important. I think that should be the question that we're addressing and discussing.

You talked about the fundamental changes and services aren't addressed aren't what we're talking about. I can't imagine how we're doing this before we look at what the fundament changes and services for our consumers, clients and patients would be. That just doesn't make sense to me.

Dr. Ghaly's Response: We are looking at the services. But it's not at the level of actually planning. I think the example given was, "What is the new model for integrated case management?" Actually defining that new model is not the work that's being done in the 60 day report, but it's not that services aren't being looked at.

Response: I understand that. But until we can have a sense of what those models would look like it's difficult to support or not support this. I really appreciated your comment that the agency shouldn't touch what is working.

I know this isn't exact fit. I know it's not exactly the same thing. But I watched and am watching the CCI process, the Coordinated Care Initiative unfold and have been involved in many stakeholder groups from the last 1115 waiver on to that. One of my experiences has been that the DMH, I cannot even describe the amount of work and the complexity of the spreadsheets that they had to develop to try and make it work.

Then we watch and we watch the fact that the consumers are not interested in this. They're opting out of this. I just think that's something that should be looked at, what's working and what's not working in something we just tried.

Q: Will, hypothetically, these 3 entities have direct access to the board of supervisors as opposed to having to go through the head of 3 agencies?

Dr. Ghaly's Response: I see no reason why communication with the board would change. Right now the department heads don't report to the board directly, none of the 3 do. Until a month ago they reported to the deputy CEO of the county who then reported to the CEO of the county who then reports to the board. Certainly, despite that structure the department heads have a very robust set of relationships and communication with the board. I don't see that the agency structure would change that. Even within the departments themselves I know of many examples where there are certain units that have very strong independent relationship with the board apart of the department heads' involvement. So don't think that that relationship with the board is dependent on that structure.

Response: Maybe it can even be improved.

Dr. Ghaly's Response: That would be great.

Q: The issue of co-occurring disorders and co morbid conditions, I'm just wondering at a pragmatic level if you could just tell us what do you see from what you're hearing would make it better for a client/consumer who suffers from both mental illness, physical illness and substance abuse, how this combined agency could make a difference in terms of their care pragmatically?

Dr. Ghaly's Response: I would love to hear from people in the room about what they would like to see happen. A lot of what I've heard is about steps for how you get in the door. I know from a lot of providers who have spoken; clinical staff and nurses who have spoken, they talk about how challenging it can be. It's very hard to figure out how to connect people to resources and services for whatever is the scope for things that they need.

There are a lot of reasons why that's hard. I don't want to pretend that it's one problem only. It's many different problems. It's referral systems, IT systems, registration processes, protocol, policies about who gets care and who doesn't get care, sometimes it's financing streams, this patient qualifies for 'this' so they get 'this' services and you try to link it all up.

It's very complicated so there could be a lot of work done to try to improve that front door access. I think there is a lot of work that can be done to help reduce health disparities and try to make sure that the benefits are felt broadly across population. There are a lot of populations who don't; some patients and clients and consumers get excellent service no doubt, there are many examples of people who have come forward and said, "I get great service." But I bet all of us know, in this room, certain segments of the population, whether it's ethnic groups, specific places where individuals where individuals live, incarcerated individuals, foster kids, medically challenged and frail elderly, there are a lot of patients that don't necessarily get good services and where there are disparities there are opportunities there.

Actually at the site of care those models, whether it's case management, collocation, there is a lot literature written about this, [inaudible] did their recent report, there are many documents put out there about, "What's the spectrum of services of integration at the point of care?" People wrote them and they are out there. Certainly, we could do a lot better than the models that we have put in place which I agree have a long way to go.

Comment: If the goal is to improve care certainly I hope that we maintain that goal while we go through these changes. We've talked a lot about cultural competency and the importance of that. But I also want to look at it as a broad base, that we really need cultural competency between the 3 agencies that we need to understand each other's cultures. I think that's some one of the fear, that some individuals are probably expressing in this room, that DMH has worked very hard in trying to establish a culture where it's all inclusive and to really look at the broad base in how mental health has affected many different individuals at many different levels of services. I hope at some point that's not lost.

The other thing that I think we need to look at is really, "What does integration mean?" I haven't really seen much of a definition thrown out there. We talked initially about consolidation. Now we want to throw out that term because that means doing away with something or bringing people together. Now we're looking at integration. So, like some of my colleagues in this room have been expressing, I'm sort of stuck on question #3 as one of the key questions about, "What kind of model are we really talking about?"

I just want to share anecdotally one of the roles, and I've introduced myself oftentimes as a SAAC co-chair for the city of Long Beach, department of human health and services or commonly known as the health department, and I had the great opportunity back in 2008 to be hired as their first mental health coordinator into a public health arena such as that. I can tell you, first hand, that even though that I was working within a very welcoming environment the understanding of cultures in terms of mental health and physical health, particularly in the public mental health arena, we did have some challenges in that aspect.

I think it's very important that when we talk about cultural competency that we really have not only an understanding of each other's culture but flexibility within each department's cultures to try and come together to meet the client's need, that's really what we're talking about here, the client's need and what it is. Being in mental health for over 30 years I saw the client take a back seat in the treatment for many years and now I see them into the driver seat more often. I just don't want to see that lost for whatever direction that we go.

Comment: However we move forward it's my hope as a manger, a psychologist, and more importantly as a veteran myself that we continue the forward momentum and focus and innovation that we've demonstrated here in the past 5 years, that this department has concerned itself with the mental health needs of our veterans who, regardless of VA eligibility or discharge status, it's my hope that we continue that. It's led to unique partnerships with the VA. Through our work and some of our pilot projects it's also led to national change in them approaching or accepting housing first. It's my hope that we don't lose that focus.

Comment: One of the reasons that we are so worried about what's happened it's really important that we learn from the history. We definitely don't want history to be repeated. We want to learn from it. History and the different organizational developments that have happened throughout the times have shown us that more bureaucracy has always ends up hurting the people. [inaudible] makes their services go down, the access to them is a lot worse, the delay of services becomes worse, access, the bureaucracy makes things more convoluted and makes it a lot more difficult for the culturally diverse populations, especially the underserved, un served, and the inappropriately served to be even worse and to be not only not be considered but actually kind of disappear.

In the contrary, what we need to do is to make sure that they are in the forefront. If the board's goal is to make sure that we better serve our community the way that we can better serve our community is to decrease bureaucracy, not to increase it. An overarching umbrella agency would only increase more administrative costs. I know that it hasn't been discussed yet but somewhere, somehow that is going to have to be addressed and the more administrative costs, the more bureaucracy, the less money and the less resources and energy will be geared toward the people that need it the most.

In our cultural competency committee we support integration but integration is much more than just 3 departments. Integration really must include the stakeholders, the grassroots communities, and our faith based organizations that are in the forefront, our nonprofit organizations and collaborators. We need to make sure that we bring the services to the neighborhoods rather than take them away.

In terms of centralizing, one of your questions is, "Should we centralize any services or any functions?" What we need to do is not centralize, not take away the services and the programs into a much hierarchal and much more difficult place to access but actually bring it down to the

neighborhood level. There really is no need for an overarching or umbrella agency. We need to come together in the neighborhood situation and make sure that everybody, all of the stakeholders, all of the departments that are being needed in those neighborhoods, [inaudible] all of us work together at that point, not bring or add to the difficulties of doing that.

Q: Since I represent parents of children I want to say first and foremost that I'm the first one to say that I don't represent the exact ideas of all parents but that is my concern too. When you're coming out asking for stakeholder input and you exactly don't know what the integration or whatever it's going to be is going to have how do parents comment on that? How do people who don't understand bureaucracy comment on something they don't know?

After it happens then they're going to say, "Well how come this is happening? Why is my child being moved from here to here? Why is my child being done this and this? That's my concern. We're going to change things and parents, and I know a lot of other people, caregivers, have a hard time accessing services as it is. Now if this changes, and I know they're saying there are not going to be any changes, but I can't say there are not going to be any changes. I don't see it that way. Parents are going to be lost with their children, foster parents, caregivers, whoever, because they're not going to understand the bureaucracy of what's going on.

Comment: NAMI families have spent decades developing a relationship with the department of mental health. Dr. Southard has been very open to listening to our feedback and our concerns as well as everyone in the department all the way down to the line staff. That is a necessity for families of NAMI. When we're dealing with something that is so much stigma that we have to fight every day we need our staff to be responsive and adding an additional layer will make it that much more difficult and add that much more stress to the family burden.

Comment: I'm here representing 27,000 employees. For us we're in every facet that is in the county as far as public health, mental health and health services, also in the jails, department of probation, etc. We're working very closely with all of the contractors and all of the partners out there.

Our concern is obviously this year is a bargaining year. We expect that we would continue to bargain in good faith. We also are at work diligently in many facets in different labor management groups and different process with all of the different departments. We're hoping that would continue and that, in fact, that from the bottom up that our employees could actually be released on county time to come work within the different groups out there to show and actually brainstorm what things are working and what isn't working, and also from a lot of the consumers that we serve.

We know that our obviously our employees are going to be impacted as we are trying to deliver the services. Ultimately, we're definitely concerned that all of the hard work that has been done in here and all of the hard work that we've all been working toward could be stifled in this particular process of agency integration or what we want to call it. Our concern is that all of a sudden there will be a magical hiring freeze when we've always been trying to get more staff hired so we can actually serve the public.

Q: In your summary you say that the strategic priorities of each department should align with the key goals and strategies established by the agency. If there is disagreement there what is going to be the mechanism for ensuring stakeholder input in terms of resolving those differences?

Our executive director also wants to comment that he agrees that oftentimes mental health does take a back seat. The probably that you're ultimately trying to solve here isn't going to be solved by making the system bigger.

Q: I want to raise an issue that I didn't see addressed in the various Katz memos and the other related documentation nor have I heard much said about it today. We all know from both anecdotal and an empirical basis that there is a director correlation between the size of a health provider and the percentage of the clients they serve or are purported to serve that fall through the cracks.

If you want to visualize that you can look on one end of the spectrum and see a private practice provider and on the other end we keep reading lately what's going on with the Veterans Affairs hospital healthcare system. This fact would seem to inform that we would be moving toward further disaggregation rather than the kind of aggregation that you're talking about. I just want to lay that out there and hear your thoughts.

Dr. Ghaly's Response: I think it's a good question. The question is always, "How can services, broadly defined, be improved?" I think the right model certainly depends on a lot of different factors. There are people that think it should be small units, that there shouldn't be a DHS or a DMH or a DPH; that those entities should be split up, that more should be done by private providers. I think there are pros and cons of all of those different models. I think the important piece is what you mentioned; to make sure that the system is set up that for those who would otherwise fall through the cracks and to be attentive to that.

Q: I'm going to ask you to involve with a public dialogue with me because this is my fourth interaction with you. I've watched you listen. I've watched your words change. I'm truly hoping that by the time we get to our seventh interaction which is when science says we can be friends that our relationship will have trust.

But I've got to talk about an elephant in the room for me. I believe I am hearing you say that you specifically are on loan from DHS to the CEO's office. I believe in another conversation that I heard that was for 6 months. So I'm assuming you go back to work for DHS at the end of this, or who knows what happens.

But I'm also hearing you say that your job is to write the report on the agency and I am making that with large florescent signs with 'Agency'. I'm also trained as an executive coach. One of the things you said is that good work being done. The question is, "What is the best way to get to the next level?" If that was the key question for everything that is going to go on you can't leave the task that you've been given and answer that question, can you?

Dr. Ghaly's Response: Well I'm not sure that I understand your specific question but just on the facts that you've opened; yes, my permanent role and my item within the county is within DHS' item. I was reassigned by Sachi Hami, the current interim CEO of the county from DHS to the CEO where I currently report to Sachi. The reassignment took place, I believe, it was on January 20th, plus or minus a day or two, somewhere in there. It may have been a couple of days prior to that.

There was no timeline given for my reassignment. I've heard people say 6 months. I haven't been told 6 months. I don't know how long I'll be there. I think how long I'll be there to a large extent depends on what the board chooses to do in May and then what people feel like, particularly the board, are the next steps for that.

I do anticipate that I would return to the DHS after my reassignment to the CEO's office ends. But that is not my decision. That is Sachi's decision.

Response: From the point of view of the conversation that I'm hearing in this room of the concern that we have with an additional layer of bureaucracy and the concern with the individual, who, at some point in their life faces a challenge and needs the support structure in order to rebuild their lives are you the person that can carry our message back or do we need to ask someone else to listen?

Dr. Ghaly's Response: Carry your message back to whom, to the board?

Response: Mm hmm.

Dr. Ghaly's Respose: My role is to write a response to the board that answers the questions that the board asks for a response on; and that is the opportunities, the drawbacks, the structure, the implementations, steps, and the timeframe. I will do my best in all transparency to incorporate input into that response. The comments in the report will be focused on those 5 issues with the added note that because there is so much interest in other topics I do plan, like with the alternative agency models, to at least point out that there were other points raised that are outside the scope of what the board requests a response on.

However, that is not the sole voice that goes to the board on this issue. I would encourage people to the extent that they don't like the agency, like the agency, want to see something else, to speak to their elected representatives or their staff, the deputies, about those thoughts. In no way do I see my role as being the funnel or the tunnel where all input must go through me.

My job, my reassignment, is to respond to the directive of the board. They have said that they approve the agency in concept, that's their words, not mine, and to write a report about it.

Response: I appreciate that and I think there is hope for our relationship.

Comment: You have actively been involved in a stakeholder process. I really want to underscore how we have a group have focused on, for example, identifying service gaps that exist among our vulnerable populations. So you are embedded in this and have been observing this process and I'm glad that you're here.

You mentioned in your opening remarks about social determinants of health. I had the honor of representing our UREP Latino committee and I discussed how the circumstances under which people are born, grow up, live, work, and age as well as the systems put in place to deal with these illnesses. We also know that these are shaped by economics, social policies and politics. I truly believe that's something that's going on as we speak as well as issues of trust that are continuing to emerge and pink elephants in the room, for example.

One of my worries is that when we talk about these social determinants that zip codes will continue to determine how long you live with this consolidation. Folks have already mentioned that a grassroots, bottom up approach to address these root causes of the disparities and inequities that exist within our vulnerable populations is paramount. So called social justice approach is really imperative and that's something you are hearing as we go through these stakeholder processes.

Another concern is that the agency or a medical model has no history of having a grassroots approach, in my opinion. Truly, a top down, into what our clients and consumer residents need will guide our work.

Comment: I was the first co-chair of the DMH clergy advisory committee. I currently serve on the executive board of what has been renamed, I say this because sometimes I sense there is not really good communication between all of the various entities within DMH, of late we were asked and we agreed to change our name. Clergy Advisory Committee became the Faith Based Advocacy Council. The difference between advising and advocating is not semantics.

That we adopted that approach I think reflects the fact that we became more and more cognizant to the fact that the faith community has a unique voice. We're not here to rubber stamp, even though our organization serves under the auspices of DMH, we as faith based providers who are frequently, statistically, the first place that people turn when they're in trouble, are not just some kind of a quaint icing on the cake in extracurricular activity but have a unique and indispensable role to play in every aspect of mental health, not just when mental health needs buy in so that we can swing open the gates of our community to interject projects, proposals and programs which we had no say in creating

whatsoever and to somehow mistake the coming to us for a 10 minute pilgrimage to hear what we have to say for 10 minutes, to then leave us completely and totally out of the loop, except when you need us to open up our congregations to your projects.

So the mission statement that we have, "Integrating spirituality into mental health for hope, wellness, and recovery" and that means true integration, not the icing on the cake but there when the cake gets baked, part of the ingredients. Carol Myers, she made a pilgrimage to us, and our faith based advisory committee, she sat there for the better part of an hour and my sense of it was that as far as a faith based community is concerned, and this whole project, as well as health neighborhoods, we're done. Everything will be done without us. We will not have a voice at the table. Adrian Hemet who works for the community relations group, I didn't know this, in one statement there was a list of

stakeholders that included educational, political, and labor, no mention of the faith community at all. But I guarantee that when you're ready to come back your present whatever we [inaudible] you will expect that we will open up our communities to you because you came to us for one hour.

I'm saying it's too little, too late. We've heard, Helena mentioned about this woman who only didn't hear voices when she was in the Catholic Church. Is the Catholic Church represented in this process? Do we have an ongoing place at the table? Adrian suggested that the initial proposal be amended, that the faith based community be mentioned by name and just not as a picture on a diagram, which it is with the health neighborhoods because increasingly we're recognizing that there is a great expectation that we will be there for you when it comes time for you to interject predominantly clinical programs on our communities which we're not sure truly reflect our values.

Dr. Ghaly's Response: I welcome your comments. Obviously, I think your comments speak to a broad issue that I won't try to solve in this context. But I would say that I would be happy to engage more with the faith based community. I would love to do that. The stakeholder list was developed by the department heads and then by those organizations who self-identified. I'm very open to including--

Response: Are we on that list?

Dr. Ghaly's Response: I can give you the list because there are different groups--

Response: You mentioned that there are 17 working groups.

Dr. Ghaly's Response: Those are the interdepartmental groups. I'll give you a copy of the list and let you see it.

Response: Are we on it?

Dr. Ghaly's Response: What's the name of your group?

Response: Faith Based Community.

Dr. Ghaly's Response: "DMH Faith Based Advocacy Council."

Response: That's my group but I'm really representing a larger voice here which is the general--

Dr. Ghaly's Response: I understand. There still needs to be the people, the group, and some forum to do that. I'm happy to be open in figuring that out. I don't want to shut down those lines of communication. I fully support the involvement of faith based community. In the vision statement we did incorporate in faith based community because I think that inclusion was very important.

Q: I'm still listening for, "What is the benefit of this happening?" Please get it across to the board of supervisors, "Before you do something like that again you do what we're doing now." Before you even decide you're going to consolidate you should have been out here. Make sure to reiterate what I said do the board of supervisors. Before they take on another thing like they what they [inaudible] were going to pass do the study out there first. Find out what the people think.

Q: My concern is record. I think the issue is, again, voices. I'm a commissioner with the commission for children and families. Often, health services has really looked to private partners such as Mattel's children's hospital, Miller's children's hospital, Los Angeles children's hospital, rather than dealing with issues within health services itself.

There is one ray of light at county and that's someone who's a maverick, who really doesn't follow protocol, and that's Dr. Astrid Heger. She's really developed some innovative program. Probably administration cringes but she's managed to get all of her programs funded privately.

I think talking about children, trauma is so important to realize. Kaiser hospital had the eight study on adults. It showed that adverse childhood experiences do matter later in life. I think this is the thing, here what children need.

Q: I'm head of the Los Angeles Greater Agency on Deafness and I'm an advocate for them. I want to provide some feedback. We have so many deaf and hard of hearing clients that are coming in and lining up for services. Oftentimes, their continued services, they have to come in again and again asking for these services. It's sad because before we had "signing health" and it shut down. It was an AOR.

Now what's left is one direct service, services for the mental health. There is just one agency right now and it's in Santa Monica. LA is huge and not all of the deaf people can go over there to get the services from that one place. Anyway, what we're proposing that integration I hope--what happens is when all of the departments provide services for the deaf and hearing the communication is under one problem. But there is oftentimes one interpreter. Mental health really needs skilled interpreters. They put them in these facilities and they send them home and they're still not healed and recovered. The providers don't have the cultural competency to deal with the deaf clients that they're supposed to be serving.

With this collaboration, integration, when you put these deaf people in these services and there is no cultural competency, there is no language, there is no efficiency working with these deaf clients that need the mental health. They need this continued therapy. They need to go through these models but the percentage is so low because there is no communication and no cultural competency. We have a few

organizations in the city that are working and I hope that we can see that they all be able to be involved to help this to become successful. We all need to be involved in this.

Comment: There was a discussion about the department heads reporting to the board. I understood you said the agency structure wouldn't change that, not reporting directly, but whatever their current relationship is to the board and that their relationship with the board wouldn't be dependent on the structure. In considering other models I'm thinking that maybe the most important thing that still is not clear to me is, "What

does the agency model look like?" I know you don't want to say and dictate what the structure is but that structure is critical to what we're analyzing here. Is it a structure where the 3 department heads report to an agency director and they can't say anything before they go the agency director?

One of the comments I made in front of the commission is what I saw was distributed at the cluster meeting was that the understanding that the agency model had the 3 department heads overseen by the director of health services. If that's a model that's very precise and very clear. To me that does not mean autonomy. That does not mean independence. It means that the director of the agency is the one that speaks on behalf of all the agency and not the independent department heads. So I'd really like to know, again from your perspective, what the agency model looks like. Is the purpose to coordinate or honestly is it to dictate in terms of what goes on in the health department? Are all 3 department heads co-equal or are they all really overseen by the director of health services?

A related question is a rhetorical question. Maybe you can't answer this. Would Dr. Katz support an agency model if he wasn't the head of the agency?

Dr. Ghaly's Response: In terms of the agency model my understanding from the board, and certainly when people talk about an agency and the government, not the business world, but in the government context it does imply a direct reporting relationship. I don't know of any examples of an agency where that agency is not directly supervising whatever is under the agency. Certainly, that's my understanding of what the board intends through use of that word 'agency', that's what they're talking about. Yes, it is a direct reporting relationship.

The purpose of the agency is in terms of setting a strategic direction, vision, promoting alignment, coordination, and communication. Is it to dictate? I realize that's partly rhetorical. No high quality agency director takes an approach of dictating. But obviously it depends on who's in the position, ultimately, what their style is and their manner of interacting is.

I would say that with respect to the board, and I do really believe that the relationship with the board is largely dependent on the board, on their level of interest in the topics, on their level of relationships with the individuals and those relationships can be very strong despite the fact that there is not a direct reporting relationship to the board which doesn't exist now and wouldn't exist with an agency. I don't see any reason why necessarily that agency creation would change that.

If the board of supervisors or the deputy, we can't control what they do. So I think it's a good question to ask them what their intent is. Certainly the creation of an agency itself doesn't change that. Your last question I realize is rhetorical. I'll let you present that question directly to Dr. Katz.

In the documents that I shared at the health cluster meeting there was nothing in there that the agency director would be the director of health services. There is nothing in the board motion that says the agency director would be the director of health services. Ultimately, that's the board choice, about who they appoint to be the agency director. That's their decision. They could select Dr. Katz, they could select somebody else. But there has been no formal comment on that.

Response: Is it possible that the agency director would also be one of the department heads?

Dr. Ghaly's Response: I would say yes, particularly as a means of not adding administrative cost and not adding bureaucracy. My understanding is that yes that's a model the board is interested in.

Response: So to the extent that the director of health services was the agency director then the directors of public health and health would report directly to the director of health services.

Dr. Ghaly's Response: In your example, if that's the case, it would report to the agency director when that case has 2 roles. If he kept the role of the head of department of health services and then if he was the agency director he would hold 2 roles in that model if that's what happened. Ultimately, that's the board's decision.

Public Comments

Comment: I wanted to thank the members of the SLT for so eloquently expressing our concerns about this proposed consolidation. My experience is that when a structural change like this is proposed it comes usually from a place where people aren't satisfied with the current structure. At least there is an implication with that.

I was resonating with a lot of the concerns that people were expressing. I think a lot of that is because if you take that for granted and say that there is an implication there that things are not working or that they could work better we're sort of left without an understanding or a statement or a concern about what could be working better. We have no sort of statement on the part of the board about why this consolidation is taking place. So we're left with our fears and anxieties about what it might be.

Most of us have spent decades forming relationships. I have a long relationship with the DMH. I've only known you for 5 days. So it's difficult in the context of not having a structure to react against. Several people sort of brought this up. So if we could hear from the board, and I think that should come from the board rather than from the DHS about, "What's the reason behind this?" What would they like to see come out of this? What's the added value? Do we get something that's really specific that would allow us to sort of say, "We can react against that." We might actually find some really good things that we could really go forward with.

Dr. Ghaly's Response: I agree. I think a lot of people would like to hear that from the board and certainly have the right to speak with the board and ask the questions that they want answers to.

Comment: [inaudible] had been working honesty and trustworthy [inaudible] see how things are working out between individuals, that's my gift since I was 8 years old, to see what's said and what's not being said. I'd like to send this message to the board, "I don't know," 80% of what's being asked, that's the response I heard in so many different words.

I have a bad day today. I don't like people to waste my time because when a leg is swollen like this it's connected up to your heart. My heart can pop any time. I live in fear with life and death, day by day. Can the board handle those? I'm just a few. Can the board handle those kind of clients and not waste their time in getting the help that they really need? Or do I have to keep going around in circles to try and figure out where our mom over here in her chair struggled to get out of bed and get here as early as she can to be able to come here and be able to hear the words, "I don't know." 80% of the response is, "I don't know."

I'm figuring out that my 11,720 hours and I know when somebody is hiding something from me, a skill that I live with 24 hours a day for 2 years, I'm skilled with that. When somebody takes my information and uses it. We're giving them suggestions for the new agency. I figured it out. We're doing the work for them on what works, what doesn't work. Maybe we could try this. Maybe we could try that. Do you really have an agency set up? Now, say the words, "I don't know."

Dr. Ghaly's Response: I understand what you're saying. I think all of us are in the same position together, working to collect all of the opinions, collect all of the input, put that to the board and ultimately the board will make a decision. I would encourage everyone to go forward and ask their questions. If they don't know the answers, if they don't know why the board is doing this or they don't know what this means to let those voices be heard to the elected officials.

Q: I'm here today for my staff who is the UREP co-chair for the API community. The bottom line is that if we're going to proceed with this we need more time to receive more input and feedback from our communities and stakeholders. They are so under-represented and under-served.

I'm going to share a story. I've been in the field forever. I still cannot understand why this happening and what are the advantages and disadvantages this change would have for our service recipients and communities? I usually help our consumers and families to have meetings and so on. I don't know how to respond to their questions, I just don't.

I want to thank the department because just a few years ago when we were really trying to help develop our consumer leaders and family advocates they were so intimidated and nonassertive. After a few times of attending meetings they didn't want to attend the meeting unless I offered to go with them. One time they refused go. I said, "I'll drive, let's go." We're in the van and I didn't see anybody in the back of the van. I said, "How come you guys are not here?" We had to take out the chairs out of the van. They never complain. They sat in the back of the van without chairs. That's how far we have come now. Our consumers spoke last week but it still is a long way to go. Give us more time. Thank you.

Q: I'm going to speak on behalf of the constituent base because at the last meeting we were together Miss Stephens made it very clear that our bodies cannot heal our minds. We are at a place now where there is so much decision. When you come to us with "I don't know" it's hurtful.

We need Dr. Katz to come in. If he is that important that he cannot come and meet with us face to face and present his position on why this must go forward I've seen the logos created now for the integration when you're still stating that, "We need the communities' input" what's going to happen? If it's not an actual structure, if this has been approved on basis of what was just said this is very alarming because as individuals just made testimony their lives, our lives are involved in this.

We do not like covert procedures, backroom deals, that's been referred to as, 'hoodwinked.' What is this? We really want concrete information. We'd like to know who the origin is? What's the genesis of this? Why is it important in this time, 2015, when we're going into 2020 where a lot of these issues should resolve?

Right now the constituency is hurting. If service providers, stakeholders, and administrators can't give you a clear picture do you really understand what we're going through? So we really need clear answers on what's happening, not the possibilities as what's to happen. We want concrete information.

Why is this happening right now? It seems like the constituents is not really their main focus. Right now during the integration process it seems more than the integration, more than consolidation. This is something that you do in the middle of the night. Could you please we have complete information on what the origin, what the genesis, and this has been asked from you prior to this. It's really weighed on the constituents.

Dr. Ghaly's Response: I'm happy to answer any other questions that there are on the subject. I've told you my knowledge of it. There is the LA Times article. There is the memo from Dr. Katz that's on the website. If there are specific questions I'd be more than happy to answer those. I stated earlier that if this group or any other group would like to extend an option for Dr. Katz to come and address questions I'm pretty sure he would accept that opportunity. But to my knowledge there hasn't been an offer.

Q: The concern that I have is that the doctors that are in the field and the local offices and hospitals don't know about behavioral health. We're trying to tie behavioral and physical health together. Necessary information needs to get out to the local doctors about this. That to me is very concerning. This is not just LA County. This is going on nationwide.

Dr. Ghaly's Response: I appreciate the opportunity to be here. I can be here for a few minutes if people want to come up and ask other questions. If there are other suggestions, questions, and comments I'd be happy to take those. Certainly I can understand the frustration, the desire for answers about some of the background, the desire to know what's in the board's mind, why did they vote the way they voted, how they came out, and I just want to say that I can absolutely appreciate those concerns and understand that. I will do my best to make sure that I

will share any knowledge that I have that directly answers those questions. But I think a lot of those questions absolutely I would encourage people to speak with the board.

IV. MHSA Items

Comment: I want to talk about strategy #6, community integration for individuals with a mental illness with recent incarceration or who were diverted from the criminal justice system. You have established self-help support groups for individuals with co-occurring mental health, substance abuse conditions and [inaudible] histories. We would never ask an agency to establish the medication from scratch. We would have them use what's already there from the drug company rather than having them figure out how to make the medication. It's the same thing with self-help support groups.

What we want to do is utilize the existing self-help support groups, something we don't do. You don't want everyone in the group to have a history of incarceration because then you're creating a community of people who are incarcerated. We want to integrate them with the regular community. So it's not only going to be on substance abuse, it's going to be for all support groups for whatever issue the person can go to so that they can integrate with the community, create a network of people who know them as a human being, not as a formerly incarcerated mental health consumer.

A: It's understood. We'll take it back. Your point is well taken.

Q: I really appreciate the concept of supporting caregivers in strategy #9. I'm a little bit confused about how we're supporting the older adult who has experienced trauma here. There are respite programs for caregivers although they aren't specific to caregivers, elder abuse is an issue. Usually in the situation where there is a family caregiver where elder abuse is an issue the elder may have dementia. A bigger set of caregivers where elder abuse is an issue are caregivers/social companions because of the social isolation that abuse elders financially, fiduciary abuse, there is that also with the caregivers but this is not going to get off [inaudible] and others. So I'm confused about where the older adult who is experienced trauma fits into this.

Rigo: So what I'm hearing is that you're ok with this strategy focusing on older adults that are experiencing trauma. You're ok with that. What you don't see yet is how this particular strategy will be able to get to that group. Where is it that you think it might be missing the mark?

Response: I think specific respite in situations where there is a high risk of elder abuse, I think that wording should be there. I think another good strategy to get at this would be a very focused outreach to the potential victims of elder abuse. I think what would be innovative would be to be doing that outreach with a strong mental health perspective and maybe a specific strategy such as motivational interviewing or whatever. But what I've seen in the community that isn't addressed is elder abuse where the person has a mental health issue for sure or a struggle and somebody goes in and takes advantage of that struggle, gets a hold of the SSDI check, gets a hold of the medication, all kinds of things. I would like to see that addressed. I think that would be tremendously innovative and helpful in a health neighborhood.
A: What I'd like to suggest if you and Martin maybe could talk a little bit about that and we can strengthen the strategy.

Response: I think it's a great start.

A: Yeah, there is some content that needs to be added. If that can happen, later this week that would be great.

Rigo: The examples are congruent with the community based strategies. So I'm hearing 'focused outreach' to potential victims but with the mental health perspective. To the extent that they are congruent again with this broader strategy is adds more content.

Response: A perfect group to outreach to; like the elders, are the bankers, bank tellers, it really works.

Q: What about older adults who are taking care of younger adult children to have some kind of support for them because they're going through trauma as well? I can tell you that from personal experience. I don't think that there is enough support for older adults that are taking care of adult children.

Rigo: Are you saying that because they're taking care of the kids they're experiencing trauma?

Response: They're both experiencing trauma.

Response: That's an extremely high risk group [inaudible].

Rigo: What I'm hearing is that the strategy is still on the mark. What would happen is that this is a strategy where we would be asking community members to propose more specific activities related to community based strategies that specifically target caregivers of older adults with a mental illness, not just the caregivers but also the older adult as a caregiver.
Q: Strategy #1 has to do with 0-5 including activities involving TAY and Older Adults. What about children 6-15? I don't see them mentioned and I'm afraid they'll be kept out. Then on strategy #2 it's all education for the schools, the education piece. Is there anything for training for the community people that are out there on how to recognize trauma in a child or something?

A: One of the themes across all of the age groups was about training the community. So what you'll see in the proposal that wasn't in the slides is that's going to be a basic expectation within the RFS for a lead agency. They're going to have to be able to do that. There will be a role for the DMH in procuring some of that training. We haven't worked all of that out yet. Every age group talked about that. That in and of itself is not a strategy but it will be a part of what the lead agency does.

Rigo: What about the 'beyond the school personnel?

A: I think Carmen's remaining question, I'll talk with Child about that. I don't know that--this is a specific 0-5 population. I don't know that going beyond that population may not be [inaudible] appropriate or it may not be innovative. We'll explore that.

Rigo: On the other one on school personnel can strategy #2, can the psycho education and community support be for more than school personnel, like say, a community based organization?

A: Whenever we're talking about educating the community that would be an expectation of the lead agency for the age groups that they choose. That will be covered.

Q: I'm wondering if putting something in there about volunteer positions with a possibility of future employment? Some people are not ready for going back to work. Some of the financial issues, insurance, other issues, might hamper them, might un motivate them.

A: Lisa is shaking her head, 'yes', so we'll add that.

Q: You showed 20 slides maybe. The only time that the faith based community by name specifically was in almost a humorously stereotypic way, "We're going to comfort people who are grieving." Well that's what we've always done except you're not going to be able to do any of this without major buy in from the faith community. The thing is the assumption that I always hear is that, "Of course we meant that. When we talked about neighborhood councils of course we were talking about--" I want to see it mentioned. The other question I would pose is, "Was there anyone consistently from the faith community who shaped this? Was there a faith based professional who shaped this?"

The question would be you mentioned the roles of the jails and recidivism I happened to know that there is some remarkable Catholic chaplains who do fantastic work but my observation over time is that there is this kind of like this background, like this clinical ethnocentrism which says, "Oh yeah, we'll get to that" but if it's not mentioned specifically you don't get to it. The last question would be, "Could the lead agency be a faith based group?"

A: The lead agency certainly could be a faith based group.

Response: There are no church state issues as far as you know?

A: Not as far as I know. In terms of who shaped this proposal it was the SLT standing committee of which you were all open to being a part of. Your primary had the opportunity to be able to be a part of that. In terms of the ability for the faith based community to participate each one of these strategies, as it relates to a health neighborhood, that's up to the lead agency. The lead agency is going to have to demonstrate their connection to the entities they want to bring in and to their community. The lead agency is going to be critical in terms of the involvement of agencies, CMO's, clubs, and businesses within that community.

Response: So they may or may not bring in the faith community. It will be up to them.

Q: I'm a little bit uncertain about strategy #2. There has been a ton of resources allocated to the school districts for educators to be trained in mental health first aid so this may not be as necessary. Case in point, educator do not have the time to stop in an hour long session and really meet the needs of a kid. It's to their advantage to simply identify and then refer their kid to an appropriate counselor. I would love to see, as

you said, folks from outside the school system assisting with helping these kids to meet that need. Whether it's other mentors or parents I'd like to see that.

Also, with #10 that looks to have changed in relation to what was originally discussed here.

A: Most of them have changed and that was based on feedback that they either weren't innovative or actionable.

Response: I'm still looking for a little more clarity on strategy #10 around engagement. Is this still considered around the concept of intergenerational?

A: It is.

Response: And designated to an ethnic population? I see family and I don't know how you see that playing out.

A: For the most part we would envision that intergenerational families would be from specific ethnic populations however it doesn't necessarily exclusively have to be that way. But we would believe that to be.

Comment: My comment is on strategy #2 as well. I think we should consider changing it from "trauma informed psycho education and community support for school personnel" to "school communities in health neighborhoods." We're still focused on schools but we're focused on the school community--

Rigo: Including the Nonprofit organizations and others. Sam is that consistent with--yeah. It also accounts for the early childhood context as well where often it's the nonprofit that's providing and there is no formal school system yet articulated.

A: That's helpful.

Q: I wanted to address strategy #5, the coordinated employment within a health neighborhood. As I read this carefully it looks like this is going to be limited to those individuals that got housing through the coordinated entry system. But I believe that there are a lot of people who either can't qualify because they haven't been homeless enough or they don't qualify because there just aren't enough slots. I'm wondering if this can be expanded to more people.

A: I think what Lisa said is that they'll take a look at that. The feedback that they got from their workgroup is that they wanted to focus on a homeless population because of the vulnerabilities associated with that population.

Response: There is a homeless population that might be getting housing through other means. There is also a homeless population that might be living in an overcrowded situation but are not going through CES system. They're just living 15 in an apartment. So we're not considering that population. That's a big population in the community Latino.

Rigo: That's a good point. So what I'm getting is that if we restrict it to only those that are currently in a system we may not be able to work with others that are either at high risk for being homeless or are homeless but not in the system.

Q: My question is not about the strategies as much as when we were having our work group we talked about 6 different areas that we were going to look at. One was to look at the skid row area. Did we abandon that? Just give me an understanding of why.

A: So at the end of the meeting inside the department we talked a little bit and thought that probably the best way to do this was to divide by 5 as opposed to divide by 6. If we included skid row specifically then you're privileging certain supervisorial districts. I think the 5 would give you more money per [inaudible] district and more opportunities to actually fund more agencies because there will be more money.

Q: For strategy #6, number 1 where it says, "benefits in scope of treatment, stigma and community resources" is it possible to also add since you're training the court and the different parts of the criminal justice system to put in the possibility of diversion so that they don't stay in jail and have diversion?

A: We'll work on the training component of that. There are a lot of options there.

Response: Once the judge is in all [inaudible] the model is working in other places and if they could be trained there is a chance that more people can get that.

Rigo: But diversion is also an outcome of most of this as well. It's named as an outcome for the whole strategy.

A: We don't want to replicate what's already being done in the mental health court program.

Response: It's not. It's not being done enough.

Rigo: Your point is well taken around the diversion piece.

Q: Back in May or June when we started this I was sort of curious about the existence of the health neighborhood infrastructure. I think the answer was, "Yes." Now I'm having a better understanding that the proposers that might come in on any RFS or whatever goes out, they will be responsible for defining the health neighborhood that they will construct by liaising with various elements in their community. Is that correct?

A: That is correct. They will select the strategies based on the coalition that they develop.

Response: So the health neighborhood that will be created on any one of these contracts will be defined by the proposer not by whatever else was existing before?

Rigo: We'll go back to that conversation right after the strategies.

Comment: Don't leave out training the school personnel, please.

Q: In TAY #3, I don't see HIV anywhere or traumas associated with STD's. It's very important.

A: Thank you.

Rigo: Right now what I'm asking is can we endorse the MHSA Innovation 2 strategies, these 10 strategies, with the recommendations that you just gave? The clock is in. "A" is you "strongly agree." "B" is that you "agree." "C", you're neutral. "D", you disagree. "E" you're blocking the motion. If you do block the motion then you have to present an alternative. Then we do another word of discussion and deliberation.

This passes again. 89% either agree or strongly agree. 1 person is neutral and 2 folks strongly disagree. We now, hopefully for the last time, approve this.

Let's move into the implementation questions. For this part here we're going to take feedback but we're not going to ask for folks to vote. It's making sure that you get your questions clarified. If you disagree with an idea you can give your feedback and a workgroup internal to the department will take a look at all of the feedback today and try to put together the best implementation approach as possible.

Comment: I understand, now that you've explained, the change in the strategy, the change in the methodology in where we're going to go with this. But I see the opportunity also because the strategies included concerns that I had for that area. So it'll be up to whomever in that area if they want to pursue something to help their community out. I understand.

Q: I'm not very clear about when you say 5 district supervisors, [inaudible] districts and 2 neighborhoods will be chosen, 1 or 2 of each. Who is going to choose them? Secondly, if we choose a health neighborhood is that going to be just the method to that geographic area or can we go from geographic area to another? Is that possible?

A: One of the reasons why we chose supervisorial districts, and we chose to do this the way I described it, is because there was a tremendous amount of differential feedback about which communities, and if "my" community is left out there were feelings about that. So basically what will happen in the next couple of weeks the department is going to modify the RFSQ to get on the innovation bidder's list. It will be completely different because the last one was about integrative care for attracting specific agencies. We'll develop the criteria that an agency then can send their information in. As long as they meet minimum mandatory requirements then they can get on the list to then bid for these neighborhoods.

What will happen is that through the bidding process will develop an RFS like we always do for our bids. It'll step by step what an agency needs to be able to do, the partnerships it needs to be able to demonstrate, the strategies it is recommending for that neighborhood, how they're consistent with maybe neighborhood charters or things along those lines and then they will say, if our budget is around $4 million, "We're

going to use $3.2 million and here's how we're going to use it." All of that will be scored and the department will do that scoring in the same way we do other RFS's.

Rigo: There is the possibility that for example you would be creating evaluation panels, right?

A: We do.

Rigo: When an RFS comes in a reply to a request for services or a proposal then there is an evaluation panel that gets formed and the members of those evaluation panels need to be free of conflict of interest but have enough to gather expertise to be able to support--

Response: So is this going to be a 2 step process? First the agency will apply for the neighborhood and then it will apply for the strategy?

A: It's a one step process. But what I described is that in order to bid on something you have to get on a master agreement list. We're developing the criteria to do that now. Once the bid comes out the bidders' conference will happen. Then a proposal will be developed and submitted to DMH.

A: This whole thing, allocating by sup districts, it's not an easy thing. In fact, I think this is probably the first solicitation that we're putting out there that the allocation is being done by sup districts. Historically we've always set them by service areas. But I think this might fit a little bit better the way we're doing it but we might have to modify it because the other thing too is that as you can see one sup district can cover several service areas or one sup district you might end up with, across the sup districts, one service area that might be giving it disproportionate numbers. So we have to take a look at that. The reality is that this has to be approved by the board of supervisors. What is their first question that they usually ask? "What's in my district?" So we're trying to cut to the chase by doing it this way but we're going to see what happens.

Rigo: Even though there are 5 sup districts there is a difference between an area, which is a district, versus a health neighborhood. A health neighborhood would be a specific location within a sup district. That geographical area would be considered the health neighborhood that applicants would have to define and then, through a collaborative, apply for funding.

The idea is that by having approximately $4 million for each of these neighborhoods we would be able to have enough resources to have a concentration of resources to have an impact on, again, the population level mental health outcomes that we're trying to achieve. The SLT standing committee that met wanted to also emphasize that we could dilute the money and then not have any impact.

Q: We have 10 different strategies. Are the lead agencies responsible for picking which strategies or are they responsible to doing all strategies?

Rigo: A collaborative would consist of a lead agency plus the subcontractors. It could be the case that, let's say, for this area there could be 2 collaboratives that apply for the funds but to serve this particular health neighborhood. So the collaborative would determine if they just want to address this age group or more than one age group and, given the amount of money, how much and many strategies.

The opposite approach would be to determine and force in some ways the collaborative to address all of the age groups. We thought that by creating more flexibility it would allow collaboratives to focus on what their strengths are and not try to do more than what they can really do. But at the same time by allowing more than one collaborative to apply for that health neighborhood would also other collaboratives on other age groups if they wanted to.

Q: My overarching question regarding the process and I understand there are [inaudible] that are involved in this for a very long time but how does this correlate with the county, the district [inaudible] strategy, Jackie Lacey's workgroup regarding the training initiative that she is trying to implement, I think it's a wonderful innovation strategy. I think it's well worth doing because a lot of the other agencies, not to be disparaging, but they are really not resource rich in being able to provide and/or to accomplish this type of training, the basic mental health recognition that's necessary to engage this population.

I love this strategy, I like the way it's worded but I'm really curious how that [inaudible]. I was at a recent meeting with the chiefs of police association of LA County and they're very lost. I think there is a feeling of disconnect between the county of mental health and the district attorney and the chiefs of police in engaging and making this process move forward.

Rigo: This would begin by having a collaborative that has an interest in implementing that strategy using a health neighborhood approach. That collaborative, compared to other collaborative that would also want to implement this strategy for a health neighborhood, a collaborative that also shows that they could leverage resources or connect with other resources. We're looking at kind of "bonus points" as well.

The [inaudible] of integrating and connecting with all of these other resources and initiatives underway would be the collaborative to be able to show that they have the capacity to move forward with this. This would allow the collaborative to have resources to be able to attract even more resources to that healthy neighborhood, for example with what you mentioned in regards to the training work with Jackie Lacey.

Response: I do understand. So the question is that traditionally with large governmental entities like the LAPD, you know, RFS's are not practical sometimes. They're rarely practical. I've been down that road before. So for a collaborative group like the chiefs of police association where they're regional so by their specific cities, whether El Monte or Alhambra, which could be a health neighborhood, how they leverage or are able to engage, I invited them to come. I told them they should be involved I this process.

Rigo: I think that issue is going to be an issue that we're going to face across other networks and other stakeholders. So part of what we want to do is get the word out through orientations, etc so folks know what's available and why and how to apply. So we'll be having to do that kind of educational work.

Q: To the extent that these strategies are going to be implemented by preexisting health collaboratives or health neighborhoods I'm thinking that in addition to the learning questions that are listed here it would be very interesting to measure the impact of this initiative on those preexisting health neighborhoods in terms of future commitment on working on future trauma issues, how in fact this small investment might have leveraged itself into something really interesting coming out of the health neighborhood.

Rigo: I have a picture of a health neighborhood 'before' and then 'after.' As the funds come in--

Comment: No funds--just the applying process--

Response: No, not the applying process, the whole process.

Rigo: So we have a 'before' and 'after' and I think part of the evaluation group, the team that gets hired, can help us track the growth in both resources and capacities...

Response: The way that the structure here is all looking at the individual impact on trauma and response to trauma or reduction of trauma, I'm actually thinking of something a little bit removed from trauma, just the impact one step removed on the whole way that the health neighborhood thinks about dealing with trauma in the future. So it really is looking more at, "Is this a pilot project that then disappears or is this something that has changed that whole community?"

Rigo: Yeah. I think that can be part of the evaluation.

A: So what you're talking about is really more than just sustainability. We all have to respond to RFS's where they ask about sustainability, what happens when the money is no longer there. We always usually give canned answers. But this is something different. It depends on the strategies. I think for the age group leads as well as the folks who were part of the standing committee these strategies, that was one of the factors, that these things be sustainable not just in terms of the funding that's required but can these things eventually be incorporated into the neighborhood, be incorporated into some of the things where the capacity is there already, [inaudible] expand, those kinds of things--

Rigo: Yes, so for example going back again to the faith based organizations this isn't just something that goes in and out but that endures, same thing for the others, like the school systems as well, we want to track the extent to which the capacities can be sustained even after the funding period ends. That is a key piece to that evaluation.

A: And that was really one of the reasons why we thought it was necessary to move away from funding services, hiring social workers, clinicians and those types of things because we know that's something that can't be sustainable. Things like the establishment or the [inaudible] or the expanding [inaudible], but self-help, peer support groups and those types of things.

Comment: I actually like the idea of taking the groups that don't get funded and tracking them to see what happens as a control group for the people who do get funded and see what our outcomes are like. I know just from my own experience with family preservation and the SPA

things that just having those meetings, even though service area 5 never got a family preservation thing, improved what was going on as we were applying for trying to have collaboration for stuff.

I think it's really important that we do outreach prior to the bidder's conference and that we talk to the neighborhood and that we talk to the neighborhood councils and the other community organizations that we want to be participating in this so that they know what's available so that we can get really good proposals coming together.

Q: At the beginning Debbie mentioned using the health neighborhoods from the Best Start. I wasn't clear how Best Start, because that's a specific age group, so I wanted more clarification on that. The other thing is that in these collaboratives it's possible that an agency that's within multiple districts might be applying for even different age groups or different strategies within different collaboratives within the county.

Rigo: That's correct. The 2nd one we talked about in the standing committee. That's the flexibility that we wanted to give to organizations and collaboratives so they don't just have to be focused to one [inaudible] district but if they have services and capacities to work in other areas that's open to them.

A: One of the things that we know that, given the amount of time for this, that we can't develop something from scratch. So when we took a look at the neighborhoods what were some of the initiatives that were already in place? So Best Start is one and California Endowment is the other. So we look at those communities that have that kind of action going on already. So when Debbie mentioned that the age group leads talked with Best Start representatives as well as folks from California Endowment it was just to get some feedback based on what the standing committee had recommended.

If these types of strategies, if there is some congruency there, in something that has been identified as a need of some of those existing neighborhoods already, they don't call it trauma but it's everything except calling it trauma. It is trauma. So that's part of the reason that why wanted to meet with them, to find out, do a reality check. Based on what we're proposing, you just can't go into these neighborhoods well "We're DMH and this is what we want you to do. This is what we think you should focus on." There had to be some work already developed in those areas.

Rigo: Initially the proposal to the SLT standing committee was that collaboratives could only apply in those areas where Best Start or California Endowment or these other foundations have already been building capacity. What the SLT standing committee recommended is that certainly if an organization, a collaborative, wants to apply within those communities, great. But if there is another community that can also demonstrate community capacity such as organized residence, organizations with capacity to do this, active networks, resources and also community partnerships, for example, Santa Monica we already heard has that kind of infrastructure. And then there is also non First Five LA, like Magnolia place, etc., that those could also qualify but they have to be able to meet a certain minimum set of capacities because we don't want to start with a community that doesn't have those capacities to be able to implement the strategies within this 4 year period.

Response: So just as an example central Long Beach was identified by both. Instead of having it focus on any particular ethnic group it could have a lead agency that would have partners that could focus on the TAY population, another agency could focus on incarceration and all that but it would be part of the health neighborhood, but have different components from the same community.

Q: As we go through this it's really obvious that we need to reach to a granular level within the communities. With that said we have this threshold of being on the master vendor list. So somehow I'm going to ask you to consider how do we reach to the lead agency? How do we reach to the person with the capacity to be on the master vendor list and yet reach past that into subcontractors that would normally not make that threshold and yet could be doing phenomenal things in the community or could be the ones that have the trust and relationship building? So I think I'm asking for a tiered approach to this.

A: One thing that's different in this particular solicitation that's different than our traditional direct service model is that agencies can subcontract. So you're going to have a lead agency and then have the ability to subcontract with some of these other groups that you mentioned. But whoever the lead agency that wins or submits an application or wins the bid has to be on the MHSA master [inaudible] list.

I think the plan is that we're going to have to amend that list to include the requirements for this. As much as I would like to get more folks involved I also know that no good deed goes unpunished. The last time that we tried to do this the expectations were raised so high that people that they were going to be given essentially the money.

A: Part of the process will be that prior to submitting a bid they will have to have surveyed the health neighborhood in part of the process. So part of the RFS will show that they've gone to the community and reviewed the menu items and the community has had feedback for the input on that. So they will not be able to just put a proposal that they think that their individual provider would do a great job. It's a requirement of this process that they survey their community.

A: There is going to be a bidder's conference on all of this but there might be some of you here that might be applicants. So this is the thing where we have to start to be very cautious that we might give folks an unfair advantage by being part of SLT versus those who are applying who are from the community. That is a very good suggestion. Whether it's going to happen, you have to apply, get on the master bidders list and go to the bidder's conference to see if what Wendy says actually happens.

V. Public Comments

Call on Monday from National Mental Health Clearinghouse

Q: Want to know more about the neighborhood councils and what that consists of?

A: Partnerships that are community partnership that are, already in those places. We didn't want to predetermine one council or community partnership. The idea is that we have experiences with collaboratives that get money to go into a neighborhood and then they leave. We don't want that. We want the collaborative to be able to work with an existing council that has that residence.