LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

COMMUNITY LEADERSHIP TEAM [CLT] MEETING

TUESDAY, NOVEMBER 23, 2021

2:00 – 4:00 PM

>> JOHN FLYNN: I'm going to disable the mic for the attendees. Any of the people in the attendee list can unmute themselves at any time. If you're having trouble, you can raise your hand and we can assist you that way. I'm about to throw the meeting live if Rigo's ready. When I hold my thumb up, we're live.

>> DR. RIGOBERTO RODRIGUEZ: I'm ready.

[Meeting begins]

>> DR. RIGOBERTO RODRIGUEZ: Good afternoon members of the Community Leadership Team and guests and others who are joining us today. It's a pleasure to be here with you at another quarterly meeting of the CLT. Before we start, I just want to let everyone know that the meeting is being recorded. We record these meetings in case some folks aren't able to show up today. We all lead very busy lives and they can see this session subsequently. So just I guess this is to let you know, show us your good side, right? So [Laugh]

that way we can record it well.

For those of you who are new and just joining us, whether you are a new co-chair or a guest, I am Rigo Rodriguez, I'll be facilitating today's session. And just to be clear about my role, my role is to help us stay as focused as possible on the outcomes and objectives for today. Also, to do my best, to help us stick to the timeframes that we have for the agenda. I know sometimes that's a challenge, but I'll do my best and also to help us follow our participation principles that we've been using for the CLT. These are basically files that we have been using to listen very actively to others and also to yourself, because as we're listening to others, we also have an internal dialogue going around what we think and whether we agree or disagree with the other person. And sometimes it's important to kind of understand where we're at on a given issue. So let's listen actively.

Trust always that we are trying our best. That's why we are here, and that's why we dedicate ourselves to this work. And so if we can at least give the other person the benefit of the doubt whenever we hear something that always helps. We always try to offer each other respect in this space. And one way we do that is by avoiding personal attacks or attacks on our character. Again, we're all here for, I think, the right reasons. And then we also explore our differences during this timeframe. You know, we do express our different opinions, but if we can also try to find convergence, so as we explore our different views, opinions,

we can also at the same time, figure out where we have a shared understanding, shared opinion, et cetera. And as always let's build together. Let's be constructive as we move forward.

There are some online etiquette items that we use and mute if you're not speaking. Please use the raise hand function. If you are not able to raise your hand, you can also use the chat box to let us know that you want to speak and then we'll keep track of the speakers list that way. Given that we are interpreting and doing all sorts of things online, it really helps to only have one person speak at a time. And then, finally, let's do our best to monitor our air time. There are so many folks in this group and if each one takes five minutes to talk, it'll take the whole time. So just try to be as concise as you can. And sometimes we can't be as concise because we're working an idea out, that's okay, too, but just trying our best.

Okay. So those are the as I shared with you, my role, participation principles, and also online etiquette. Let's do this now in the chat box, can you go ahead and put your name and group or division just that way we know who is present. And if you are a new co-chair for SALT, UsCC, Cultural Competency Committee, just go ahead and put that in there. So if you can do that in the chat box, just kind of welcoming folks to see who's, you can put your name. Let's take a couple minutes just to know who's here. If you want to share some welcoming comments you can do that as well.

And Seta, is that how you pronounce your name Seta or Seta? LaVon, welcome. Great to see you. Pinki, Kevin as well. Alejandro, City of Palmdale, well, joining us from there. Cody, welcome. I'm just sort of seeing like Rick. Great to see you again, Harold Turner, our commissioner, welcome. I'm just sort of picking and choosing as names come up. Bianca, welcome. Esiquio, Yolanda, welcome. All right. Daniella, who is, I guess, the co-chair, for the Latino UsCC, welcome. So it's Daniella Hernandez. Welcome.

Okay, well thank you all for sharing your presence here with us. I'm going to transition now to another slide and also to share with you some sad news that we were just informed about yesterday. As you can tell, we're all introducing each other and a person who would be typically here introducing himself, it would be Sunnie Whipple. And it really saddens me to share with you that -- the passing, I'm sorry, I'm getting emotional, of our dear, dear friend and colleague Sunnie Whipple this past Sunday morning. And Bernice shared this news with us yesterday. As you all know, Sunnie was a warrior in the truest sense with just endless compassion, boundless humor, disarming wit, and fierce wisdom. And so his memory will certainly always inspire us to follow fairness, justice, and love. And, you know, I could say more about him, but just Bernice shared with us that further information will follow, particularly around raising funds to send Sunnie home to Rosebud Reservation and to his family.

And I'll ask for a moment of silence in a second to remember Sunnie and

embrace his spirit. But before I do that, let me see if there are, you know, a number of you who would like to share something. I know you were all sharing in the chat box, but if you also verbally want to share something, just let us know, and we could maybe unmute. So if you want to say something, maybe one or two of us. And go ahead, Rick.

>> RICK PULIDO: Yeah, I'm just -- it's overwhelming. I feel for my brother Sunnie and his family, my condolences from all of us from DMH here in L.A. County and all of our brothers and sisters, of course, throughout the world. Sunnie was an iconic man in my life because he taught me a lot. And I'll just leave you with the thought that Sunnie, I called him chief one time, he goes, "Pulido, I'm just like you, man. I'm just a brother, man, please. I'm not a chief." And I stuck with me. I said, hey brother, in my heart, because you're a leader of the pack and a real true warrior, like you said Dr. Rigo and Dr. Sherin and I know Sunnie straight from the heart, all my love, all my feelings. I'm going to get emotional here, but all my respects to brother Sunnie and his family and God bless you brother. And we'll see you in heaven one day, you're setting the table for the rest of. Amen.

>> DR. RIGOBERTO RODRIGUEZ: I see, someone's hand is up, but I -- let me see the participant list.

>> JOHN FLYNN: Bianca.

>> DR. RIGOBERTO RODRIGUEZ: Bianca.

>> BIANCA GALLEGOS: Hi, good afternoon, everyone. I'm sorry to hear the news. I want to -- right now, what I, just every time I think about Sunnie is about how instrumental he was to saving the underserved communities, the Latino UsCC. So thanks to him. Thanks to his effort. He saved all of the UsCCs. He was huge. And he was like one of the extra voices really needed one of the extra supports. And I just want to say that thing because of him in the effort of, along with other members. I really always feel that even though he was more on the behind the scenes, he was very important and I'm going to miss him. Thank you, everyone.

>> DR. RIGOBERTO RODRIGUEZ: Thank you, Bianca. And I know that Bernice, I don't see her here and I don't want to put anyone on the spot, but I did see Wendy Cabil, you know, send our love to Bernice as well. So if we can also join Bernice. So ever since I've known Sunnie, I've known Bernice.

So, Dr. Sherin.

>> DR. SHERIN: Yeah, I don't pretend I've known Sunnie nearly as long as we're -- as closely as obviously many, many people. But I remember the first SLT that I ever went to, and I remember Sunnie such a strong but really gentle voice. And you used some great terms, Rigo. I would say that he was so gracious and had such gratitude and he was compassionate. He was funny and

he was wise, but he was also incredibly tolerant. I mean, he was tolerant of such -- so many things for a long, long time and I gained a lot of strength. And he gave me a lot of hope. So I miss him. I heard about it last night. Anyway, he's with us. He's with us, he will be.

>> DR. RIGOBERTO RODRIGUEZ: Dr. Sherin and, you know, it's -- I think there's one more person that has hand up with that. Am I missing someone?

>> RICHER SAN: This is Richer, Rigo.

>> DR. RIGOBERTO RODRIGUEZ: Yeah. Richer, go ahead.

>> RICHER SAN: I'd like to say something. Again, I'm Richer San, I'm one of the co-chairs of API UsCC subcommittee Department of Mental Health. I've known Sunnie and Bernice for about a year and a half. We met. And Sunnie, I remember him. He always encouraged me to speak out, to share. He attended our subcommittee meeting to encourage, and I always share about him with my wife. I say, you know, I met a great friend and one of them is Sunnie. And last week, at our last meeting, you know, just -- it was just before the meeting he was asking me, "Hey, Richer, what happened to your parade in Long Beach?" I said, Sunnie, we are planning. We are planning, like we're going to bring back that street parade and you're going to be there. You're going to be there, my friend. I said, make sure that he has a special reserved parking. I told him; you will be. Sunnie, you're going to be there. If you can walk, you walk with me and I'll make

sure that you enjoy all the food and entertainment that my community have.

I am shocked, gentlemen and ladies, today. I am really shocked. I just talked, we just talked. And again, he had done a great deal for our subcommittee. He helped us and he's a straightforward guy. I like him. He just shoots his mouth off and then he always says, Sunnie, we are brothers. Remember, we do talk a little bit about the last meeting and so Sunnie, we all here together. We learn from one another. I have learned from you and you should not go anywhere. I'm sad today. And, but again, Sunnie, you rest in peace. His culture and my culture are very similar and so I'm sure that I will see Sunnie. And again, I'm sad to hear that and thank you so much.

>> DR. RIGOBERTO RODRIGUEZ: Richer, thank you so much. And he will continue to be with us, may rest in power and peace. And it's so hard for me as a facilitator, and I know you as members of the CLT to sort of go back to business on the agenda, but it's not business as usual today, right? It's making sure that we embrace this spirit and kind of renew our commitment to the work that we're doing. And if you allow me to kind of keep going today in the meeting. I appreciate all the wonderful, beautiful thoughts that are in our chat box. And it just grounds us back in our purpose as a Community Leadership Team, right? We are all individuals linked to our communities coming together to really, as a really I network of leaders where we use our experience to gather information experiences and try to do the best we can to improve this important system,

driving recommendations to improve. And that's what he did all the time. Right? And so it's -- this is the space for us as community leaders, for us community leaders, with the department to keep pressing for this important work.

Again, I thank you all for the wonderful, beautiful comments in the meeting chat and really our intention when we come together along with the director, Dr. Sherin, and key staff like Pinki and others, it's to really make sure there's an interface between us, between you all to strengthen this collaborative relationship, because it's that collaborative relationship that improves systems and ultimately improves lives. So thank you again.

LaVon asked if we could let her know about how we can send Sunnie home. So I'm going to maybe turn to Pinki later on and ask if she can contact maybe Sunnie and perhaps send out an email to all of us around how to support this effort. Pinki, is that okay?

[No response].

Oh, she's muted. Okay. So I'm assuming that it's okay, right. Okay. So we'll come back to you on that. Okay. So thank you again. I'm also in shock, but the three reasons that we're here today for is to provide an update on the Call Center redesign efforts that have been going on over the last couple of months; also, to share a presentation on LPS reform efforts and provide some constructive feedback, just like what we did with the Call Center redesign efforts,

and then around three o'clock have a community conversation with Mayor Darrell Steinberg, who you probably all know has been so instrumental in this work.

So we were thinking that we'd start off with a 10 minute update with Susan and Michelle on the DMH Call Center, then take about 50 minutes to go through the presentation on the LPS reform and then around three o'clock-ish then shift over to the community conversation, and then five minutes for closing the next steps. Okay?

All right. With that, then let's -- the first one is Susan Cozolino and Michelle Young. I'm going to go ahead and take down my slides because I think you're going to use your slides. And I'll just let -- this is just an update, folks. We won't take questions. You can put your questions in the chat box, but this is mostly just an update. And so please do so. Let me take my screen down. So I'll hand it over to Susan.

>> SUSAN COZOLINO: Okay. Thank you, Rigo. And I'm sorry for such a significant loss that you've all experienced. So I hate to jump into this after that, but we'll forge forward.

So my name is Susan Cozolino. I'm a psychologist with QA, Quality Assurance Unit. I'm here with my colleague, Michelle Young, and we both work with Jennifer Holman. She is our leader and she is the one who had presented a bigger overview to all of you last time. So I'm just going to give a status update

regarding our call center modernization. So we broke it down to five key pieces. The first, let me get rid of this, the first part as you see up here is something that you've all been a part of when Jennifer presented the plans to develop a modernized call center, more user friendly, efficient, and 21st century. So present results to all of you, the SALTs.

And then we had the opportunity over the four-week period to meet with the work groups. We had leaders from the CLTs and the SALTs, and we further addressed the needs of the community and incorporated their feedback into what we're going to be developing, which is number three. So we are in the process of developing a prototype, which is basically a visual diagram of the proposed call center. And then we are going to, once we get that done, we are going to then present it to the larger CLT and the SALT community and kind of go through the nuts and bolts of it and see if there's any gaps that we need to address. Then the next part, number four, is actually going to implement any of that feedback to further improve that prototype or visual diagram. And then we are going to get a vendor we're selecting a vendor to build that application. And it's going to be based on the prototype, which includes all of the feedback from all of our stakeholders. So that's it in the nutshell.

This next piece is just, these are just some key pieces from the feedback that we did receive that we made sure to implement. Some of the key things focusing on talking to a live person instead of pushing buttons, this was

especially true for when a client or a caller calls for a crisis reason. They need to have an immediate connection with the clients if they hang up or if they get disconnected, we may lose them. The language is extremely important getting that at the outset of the call and then following it through so that, for example, if it needed to have PMRT dispatched, if it was a Spanish speaking or if there was a hearing impaired that they would actually have someone on site from PMRT consistent with that language. And also, callers requesting an appointment, they wanted to know, okay, I called and now what? So they want to be clear on what the next steps are and making sure that the provider who the referral goes to actually gets back to them ASAP.

The other piece because our call center modernization is not just about the phone. It's also about our website and some of the online features. So we talked about the provider directory, making sure that that's going to be easy to navigate so that the community and the clients can actually navigate that and identify providers that they want directly the overall website, making sure that that is user friendly with self-service tools, which we currently have with iPrevail. But we're updating that provider directory, also having video chat, texts, and different call options.

The overall piece there was to make as many options as possible, keeping things as flexible as possible. And then having, so the community has different options and flexibilities. Another comment regarding the deaf and hearing

impaired regarding the website was making sure that we have something accessible online for a video chat. So again, these are -- this is just a sampling, just wanted a high level of some of the key feedback that we received from the leaders who then gather that information from all of you.

The last piece is the timeline. Just so you have a sense as opposed to making it ambiguous categories and where they fall. We're going to have the prototype or that visual diagram completed in December then in January we're going to be presenting it here at the SALT meetings, getting that feedback from all of you and then incorporating that, getting the -- in February, by February we'll have a vendor and we will then start actually creating the application. And that's like a six to nine month window from the time we have the vendor in February to the time that it should be completed. So we're looking at the end of next year to have a modernized call center.

So that is it in a nutshell. And I will move on to our next agenda item, but thank you all for your feedback. And again, in January, we'll be presenting our prototype.

>> DR. RIGOBERTO RODRIGUEZ: Susan, that concludes the presentation, right? Michelle is not going to share anything else, correct?

>> SUSAN COZOLINO: Unless she wants to.

>> DR. RIGOBERTO RODRIGUEZ: Okay. Just checking. Just checking.

Just checking. Thank you, Susan, for this update. Again, this was scheduled as an update, I think Dr. Sherin has his hand up. Dr. Sherin, do you want to share anything else?

>> DR. SHERIN: Well, just a quick comment. I mean, I do think that the presentation that Jennifer Hallman did was an example of the kind of thing that we want to do. We want to bring programming out into the community and get the kind of feedback that we've gotten. So I just, I want to continue to encourage that approach in a big way. So there -- really there are three things that I'm thinking about as I heard Susan's summary. The first is community feedback and it keeps coming and it's iterative. The second thing is flexibility. We're not a flexible department, you know, bureaucracies are not always flexible, and this is a really, really important part of the department because it's really an interface for so many folks.

And then the third thing is, that I don't think was mentioned, our goal is to actually be able to literally get appointments with psychiatrists and clinicians through the phone. How long is that going to take? I'm not sure, but we've gotten the feedback. I think it's really an important access initiative and aspect of any call center that's operating in the 21st century. And that'll be one of the things that we would want anyone helping us to incorporate. And That requires a big culture change in the department. I mean, there are probably a lot of people that are not crazy about it, but the idea is we need to figure out how to improve

access in real time.

>> DR. RIGOBERTO RODRIGUEZ: Thank you, Dr. Sherin. And that's actually a really good segue to our next topic because one of the things that Susan, Michelle, and Jennifer have done is, along with the CLT, really demonstrated what collaborative planning looks like. And so they came, gave a presentation, we took a lot of questions and then they were able to hold some ad hoc teams where they were able to go deeper into the feedback so that the input isn't just coming from within the department, it's coming from leaders in the community with respect to how to put together and design something. Now, there's still more work to do. And so thank you, Susan, for highlighting that you'll be coming back in January, both to the CLT and the SALTs, to do some additional -- to obtain some additional input.

Now, I know there are hands right now raised. If you could articulate your question in the chat box, we will, as Pinki mentioned, we will circle back with you on this. We do need to move to the next item, which is an item that we're going to collect input on. I appreciate your patience on this. So let me get this going. So for the LPS's reform, we have a presentation headed up by deputy director, La Tina Jackson, along with our colleagues. Here's what we're going to do. We're going to take about 25 minutes for the presentation, and then we'll be opening it up for constructive feedback, just like what we did with the call center. We're going to see what you liked about the presentation, followed by what

questions you have, and then any suggestions that you have. So with that, let me turn it over to La Tina.

>> LA TINA JACKSON: Good afternoon, everyone. And thank you so much for allowing us to be here today and to present to you. And, you know, I want to echo kind of what Michelle said. I'm so sorry for your loss and my sincere condolences, and I think in line with the mission of SLT and Sunnie's commitment to this work. I want to present this program to you and kind of the work that we've been doing around LPS reform and how we manage LPS in its current existence.

So today I'm going to be presenting about the HOME Program, the Homeless Outreach & Mobile Engagement team, and some of the amazing work that they have done over the past year with Dr. Sherin's vision and leadership. I'm going to start with a little bit of laying out the context of the work that we do in general, within the countywide engagement division, which is a division that is dedicated to serving our most vulnerable individuals in the county, those people who are disengaged from treatment and sort of residing on the peripheries in our institutions and, sadly, on our streets.

I'm going to give a little bit of context of the work that the HOME team does, then my colleague, Anthony Ruffin, will speak to kind of the philosophy behind the work and the practice that we engage in to execute these -- the

mission, and then I'll outreach the program manager of the program will speak specifically about the pilot and the work that we've done over the last year. And I just want to note that while this started as a pilot, this is work that the HOME team has adopted. It continues to be a standard part of the work that we perform and that we are happy to provide this service to the community. I'll certainly appreciate any feedback, suggestions, or dialogue that we can have with the community around this work. So let's, we can move on to the next slide.

So just to paint the scale and the context of what we do, the whole team, the Homeless Outreach & Mobile Engagement team is a specialized team that exists in the context of a larger countywide outreach strategy. Some of you may already know, so forgive me if this is redundant, but I think it's important to know that the county under the Homeless Initiative, funded by Measure H, there is a larger, coordinated outreach strategy that consists of not only the Department of Mental Health, but also our partners with Housing For Health and their contracted street outreach teams and the Los Angeles Homeless Services Authorities, which also do outreach. Largely speaking, all of the outreach teams provide proactive outreach to kind of assess where people's needs are. Why did they end up in the situation that they're in, in the first place, what's the most appropriate housing, providing for basic and immediate needs. And then there are specialized teams, specialized teams that work specifically with veterans, which we also provide support in that space as Department of Mental Health and

the engagement division, and then specialized teams that really are laser focused on providing services to the most vulnerable people living with mental illness. Can you move on to the next slide.

So all of the services that are coordinated through the larger E6 strategy, someone could-- a community member, anyone can access LAHOPE at LA_hop.org to request an outreach team. Now, those are generalist outreach teams that do the initial contact with an individual to, again, assess what their needs are, and then determine whether a specialized team needs to be contacted to provide additional support. So again, that's LA_hop.org. You can move on to the next slide.

But of course not everyone has the same needs, right? So there's a big difference between equality and equity, right? In equality, we provide everybody the same thing. In equity, we recognize the differences between people and provide them exactly what they need. And that is what the HOME team is about. It's really meeting people who have special needs exactly where they are. There's, you know, common belief out there that everyone who's experiencing homelessness has a severe mental illness. You know, depending on where you get your estimates, some say upwards of 80% of the Los Angeles Homeless Services Authority estimated about 26%. But then there is a smaller percentage of individuals who need specialized laser-focused support because the reason that they are homeless, the functional impairment that occurs and secondary to

their mental illness is what caused their homelessness. That is the population that the HOME team is laser focused on. You can move on to the next slide.

So essentially we are specialist teams really hitting that sweet spot right there in the middle, both between the generalist teams and the specialist teams, and that we do provide a proactive outreach and provide for those basic needs, but we also provide relentless engagement to determine when a person has a severe mental illness, what other interventions need to take place? Whether that's as a psychiatrist, providing medication support or nursing, providing a full spectrum of specialized mental health care. And in that veil, pulling out the full arsenal of what the Department of Mental Health can employ, whether that's to play someone on a 51/50 so that they can get the acute care that they need in hospitalization or looking at longer-term solutions, such as conservatorship, where that's applicable, where someone is truly greatly disabled, which is the pilot that we're going to cover in this presentation today. And I'm going to move on and pass them on to my colleague, Mr. Ruffin.

>> ANTHONY RUFFIN: Hi, good afternoon, everyone. My name is Anthony Ruffin, the DMH HOME teams. HOME's mission. The Homeless Outreach & Mobile Engagement team provides street based comprehensive specialty, mental health care to those experiencing chronic unsheltered homelessness, coupled with severe mental illness, using a hardboard approach and harnessing the skills and specialized multidisciplinary teams: our

psychiatrists, psychiatric nurses, practitioners, psychiatric nurses, licensed mental health clinicians, substance abuse counselors, caseworkers, and peers. HOME delivers a relentless engagement, often a platter of services, including the most appropriate level of care and housing. HOME is dedicated to facilitating recovery of suffering associated with symptoms of severe mental illness and transitioning individuals from homelessness to housing, appropriate treatment, and community.

Relentless outreach. Outreach is an intensive interactive process, which involves impeded contact. And what our teams usually do is go out two, three times a week and engage people and try to attempt to engage people and offer people a slew of services, may it be food, may it be motel, may it be hygiene products, may it be whatever the client may need. And we do that two or three times a week with each individual. And as you guys know these clients, they require intensive, frequent, persistent outreach. And so what La Tina was saying this laser sharp focus, our teams are out on the ground, six, eight hours a day, working with these individuals every day, trying to getting meaningful engagement practices and building relationships with individuals.

What we try to do is establish a trusting, meaningful relationship. And what I mean by trusting meaningful, it's a meaningful relationship between the team and the individual that we're working for. What's meaningful for the individual, and also looking at the individual strengths and the clients

weaknesses. And we try to focus on what is more meaningful for the client, rather than us as a team to see if we can move the individual forward, if there's some type of housing or mental health treatment. And we've established these relationships over a long period of time, and it takes months because some people are so complicated. And we recruit really creative out there in the field. And what I say about that, we think out of the box and we're active; we do active listening, and we're gauging the kind of stress and also listening to the person's road to recovery. And we do that with our community health workers, with our nurses, with our clinicians, with our psychiatrists. And they let clients form, like, their own plans, and we try to help them with those plans to see if they're capable of reaching those goals. And that's part of sticking out of the box for us, and we let the client choose who's going to be the lead on the team. Our client may not like the psychiatrist, but they like the clinician, or they may not like the clinician, but they like the community worker. And it's up to each individual or the team to do a warm hand off to the rest of the team members. And what we try to do with all of the people on our teams, look at the whole client to each perspective; the community's perspectives, the psychiatrist's perspective, the nurse's perspective, and a psychiatrist's perspective, to come up with a meaningful treatment plan for the client.

Our HOME target population, as clinically defined, is people that are chronically homeless, seriously mentally ill, aren't able to sustain, provide basic

needs in independent context of the psychiatric disability. We also look at the rate of disability, and we also work with people that refuse any kind of care, any kind of treatment or care. And these people are usually isolated from encampments. And you usually see them sitting in doorways, or you see them sitting on bus benches for years, and they're sitting there with mental health issues and medical issues. And those are the people that we engage on a continuous basis in a community. Those are our targeted population. And we also do other work in the community by offering services and connecting people to clinics and stuff like that. We have the aviators. We go to a lot of stuff like that, but our main focus is these individuals that are at each SPA throughout the county. And that's our main targeted population.

And I will pass it to my coworker, friend, partner, Aubree Lovelace.

>> AUBREE LOVELACE: Thanks, Anthony. If you could go up two slides for me. One more. Thank you. So currently we're calling it the outpatient conservatorship program, but it originally started as a pilot in -- for 2020/2021. Next slide, please.

So conservatorship is when an individual or an agency, so a family member or the Public Audience Office in Los Angeles County is appointed by the court to be responsible for a person. So the court order conservatorship places the fundamental rights of an individualist care and wellbeing in the hands of an

appointed guardian. Generally, this is regarding psychiatric care, medication treatment. Sometimes it can be for finances. It's a separate request. Sometimes it can be for medical issues as well, which is another separate request for the court. This certainly applies for individuals over the age of 18 and it's terminated every year. It has to be extended every year. And the individual has to continue to meet criteria. And within -- while on conservatorship, there tends to be a misconception that it's an automatic year, but at any point, a client can contest the conservatorship in that year if they're stabilized or disagree with it. Next slide.

So the regular route that a conservatorship goes down is in the inpatient hospitals. So when the field teams, psychiatric response teams or outpatient clinics place individuals on a 51/50 or a three-day hold while in the hospital, it gets extended to a 14-day hold. If the client's refusing medications, they petition for a Reece hearing with the court. And then the hold has to be extended for 30 days, then an application gets submitted to public guardians who does an investigation, and then it gets submitted to the court and put on the calendar. And the client has a right to ask for a court trial or a jury trial. Some clients voluntarily agree to the conservatorship and then it's ordered by the court and then the conservator is appointed. And then generally individuals in hospitals are transferred to lock facilities. Next slide.

So there's many challenges to this process. It lacks care continuity. It

assumes that all of our clients that are in the hospital automatically require locked placements, which isn't always the case. Recovery is not at the forefront. It extends the need for individuals to be in a hospital for more than an individual needs to be in hospital for stabilization. It turns them over to administrative days. There's a loss of revenue with the hospitals. And the average wait of a locked facility is around three and four months. And it reduces our ability to get clients who have acute needs into the hospital because the beds are tied up by individuals who are not conserved. And, of course, this experience can be traumatic on many levels for our clients. Next slide.

So the outpatient conservatorship process. The goal was to approach this from a different avenue and doing it from the streets as opposed to the hospitals. So the production of it is our teams, the HOME teams are out there, like Anthony spoke about, you know, giving this kind of relentless engagement day after day, we get through a week trying to get the clients to, you know, join us, bond with us, relate with us. The clients continue to refuse all services. And at that point then the team, the psychiatrist is out there and the psychiatrist, you know, in conjunction with the team makes the determination to initiate a referral for conservatorship. We do hospitalize, if necessary, on a short-term basis. And when in the hospital, that's where they have to go, we communicate daily, we go visit them at the hospital regularly.

And then we apply for -- if they do, if the conservatorship application or

referral is received and the investigation is completed, they'll pursue the application and get a T-con, so a temporary conservatorship for the client. And then it goes through the court process that was just discussed.

So the goal of this is -- the difference is the HOME team is very involved. The teams are very involved and we try to, we know the clients, we try to assess for the least restrictive, you know, level of care for them. So not everybody has to go, ideally not everybody goes into a locked placement and that people can be served successfully in the community and safely in the community. Next slide, please.

Again, so we're laser-focused. We have a target population that we're looking for and it's a small subset of the community. And that's where we spend most of our time. It provides a much needed intervention for individuals that are on the streets where, you know, if we call them hidden in plain sight, they're the ones that are just sitting there and just, they're the ones that are going to die in the street. And those are the ones that we really focus on. We assume recovery is possible. Again, we seek the least restrictive housing option available. We maintain continuity of care. We follow our clients even once they're conserved and placed. We are available for the testimony that takes place in the court. It's our psychiatrists that are providing the testimony. And this hopefully limits the amount of time an individual is in the hospital, as opposed to, you know, the placement or facility where they ultimately end up and hopefully, you know,

recover. And that hopefully reduces the trauma experience of being in the hospital.

I will send this back to Anthony.

>> ANTHONY RUFFIN: Next slide, please. Coordinated interventions and care. HOME multidisciplinary team. As I said before, our teams have a psychiatrist, a clinical social worker, substance abuse counselor, peers, community workers, medical caseworkers, and a lot of different disciplines on our teams to bring this experience of the whole person. I'm looking at the whole person from a lot of different eyes. So that's where our team is built up like that, to handle all of these different interventions that we can do with clients. We also work with the Office of Public Guardian, County Council, Public Defender, Street Medicine Teams, acute hospitals, skilled nursing facilities, FSP, outpatient treatment centers subject to treatment settings, locked facilities, residential care, and permanent supportive housing. So we have a slew of things we can offer people, yeah. And we try to offer people a lot of different things, but most of all, the least restrictive placement first. Next slide.

So the clinical dilemma, autonomy versus beneficence. This is a person that we worked with probably over two and a half years ago. As you can see, he was laying out on the streets, isolated, severely mentally ill, have been living on the streets for a few years in that condition. And after we've done our

interventions and did our outreach and we were able to place him in an acute setting for a little while, we placed him in a board and care, and this is our guy today. So we know this program works, we know this stuff works, and we're just tackling it one person at a time. Yeah. Next slide.

As you can see, these are the people we work with when we first find them, and this is what they look like after we finish. The work is very comprehensive. The work is super clinical and the treatment plans are ongoing and ongoing and ongoing. As you can see, we've followed gentlemen from this point A all the way to where he's at now and we're still following him and staying in touch with him. And we're also in touch with family members if that's needed. So we do a lot of different care and treatment programs for individuals based on their needs. Next slide. Any questions?

>> DR. RIGOBERTO RODRIGUEZ: Thank you, Anthony, Aubree, and La Tina. We really appreciate this presentation on the current work that you're doing. I know La Tina has another, you know, time coming. I don't know, La Tina, if you wanted to add anything else to kind of close, or if we can open it up for questions?

>> LA TINA JACKSON: No, we can open it up for questions. I just wanted to just reiterate like how groundbreaking this work is to do this type of work on an outpatient basis and to assume that recovery is possible from the start, to start

with the least restrictive kind of trying to offer the least restrictive setting and just really to address those individuals that have been on the streets kind of languishing for years without any substantive movement because we can't make it happen unless we're in a hospital. So really just groundbreaking work and my hats off to this team to Anthony, to Aubrey, it is just an honor to work with them and to see the results speak for themselves, so thank you. I think you can just open it up for questions.

>> DR. RIGOBERTO RODRIGUEZ: So we're going to follow the same process that we used for the call center, because this is the new model that we want to implement within the CLT of constructive feedback. And to start, just like what we did with the other project is in the chat box for the next two, three minutes, if you could just put the things you liked, the things you liked about what you heard, just if you could just write down because as constructive feedback, it always helps to know where we are going right, right? Where things are going on. So if you can take two to three minutes, I'll go ahead and put the clock. And then right after that, we'll open it up for questions and suggestions. But in the chat box, just write down what did you like about what you heard. What did you like about what you heard?

So I'll just be reading this out. So individualized services stood out to LaVon. Carmen, she likes the comprehensiveness of it. And with, I think it's Seta or Seta, and it's kind of a sense of the program is working well. Anything

else that stood out to you add it to the chat box, if you can. So it's nice seeing examples of success. I like that it is multi-disciplinary as a team with frequent collaboration with providers that stood out as something strong. I'm happy to see that there's efforts that are making a positive impact. I'd like to sort of that it highlights the inequities and dehumanization of this work. I'm not sure if that's a constructive one, but, Rick, I'd like the integrated staff component. San wrote something which I'll ask the translator to tell us about.

Wendy -- yeah, so Wendy's highlighting the need to be engaged from the beginning to the end. And, yes, what's going to happen with this, and thank you to La Tina and the team that out of this conversation, they're also willing to have a set of ad hoc team sessions so that we can go deeper into the kinds of questions and suggestions that you're about to give. So, yes, this is going to be an interactive collaboration. Barbara highlighted that she liked the continuity of care and this idea of the VIP client, right? That so many times we hear the unhoused wants to be there and can't be helped and it's great to see that this program is proving it wrong. Reducing the trauma of getting help is so important, and it was highlighted.

And then I'm starting to get some questions. How do we refer to this program? So that'll be one question that we'll send back to you. And then the concept and how this process helps reconstruct an individual. And it has given -- that has given up on hope is important. So let me take a couple more comments

and then we'll -- oh, for the translation, I like that it can show us how much better we can go from here. Good. And then the translation from Pastor Nah is that the conservators have been very effective for our homeless population. We're not able to get from -- we're not able to get help from family and friends. I love the fact that the comprehensive treatment is consistent and the end result is reducing their trauma. Now, I think two more here. I would like to second, all of the positive comments, Yolanda, that she's sharing and mentioned. And then, Bianca, I liked that we finally see more people from the Black community giving the presentation on homelessness. So it speaks to -- give the importance of having staff members who are part of the communities that we're serving as well. Okay. So let's do that.

>> MARK KARMATZ: This is Mark Karmatz.

>> DR. RIGOBERTO RODRIGUEZ: Go ahead.

>> MARK KARMATZ: Yeah, I was just able to get on, I had a little bit of trouble getting on and then I got back to the --

>> DR. RIGOBERTO RODRIGUEZ: Can I ask who this is?

[No response].

Okay. So I'm going to -- I'm going to go through the list of folks who have raised their hand. So I have four people. I'll start off with, it says Marcus H., followed by

Carmen. And then Seta I'd ask you when we get to you how to pronounce your name because I'm sorry about butchering it. And then we'll go to Barbara -- okay, so it started with Marcus.

>> MARCUS HAILEY: Hi, I'm having problems with my chat box and there are a few things that I like. The fact that these programs make an effort to reach more targeted communities or target to reach specific communities. I see a huge hole in what's being done here. You know, the county records a lot of information and it gets a lot of information on people receiving services, and it actually can do a better job of providing preventative services to people because a lot of these things are generational and they go between generations in the same family. So I would actually -- I would hope that the county would actually spend more money on preventative services because you guys actually know who will require services in the not too distant future, and it won't be good to reach these people before they fall by the wayside and require intensive services such as these.

>> DR. RIGOBERTO RODRIGUEZ: Okay. So you're giving a suggestion on how can the department and the county invest more on the prevention end, correct?

>> MARCUS HAILEY: Exactly, yeah.

>> DR. RIGOBERTO RODRIGUEZ: So let me do take two more

comments, and then I'll hand it over to La Tina, based on the next two comments that I see what you would like to share. So I have Carmen.

>> CARMEN PEREZ: Thank you, again, for the presentation and thank you for creating something like a HOME program. My question is in regards to culturally competent staffing and services around the HOME Program. Is there something you have for the Latinx API community in regards to staffing and the way to approach people or hospitals, and what hospitals are you targeting for this program as well. So it'd be nice to know, like the culture competent part of this program as far as language as well.

>> DR. RIGOBERTO RODRIGUEZ: Okay. Let me take one more comment and then we'll send it back to our presenters. So is it "Sita" or "Seta?"

>> SETA HAIG: It's Seta, yeah. I work at Didi Hirsch. My question is kind of similar to the last one. I want to ask about cultural competence of the Armenian -- for the Armenian community, especially with the interdisciplinary kind of set up, whether we have the Armenians staff that will be willing to do this outreach. I know in my program it's been so hard outreaching homeless Armenians. There is so much stigma and shame about just being homeless, let alone engaging in these types of programs that I think it's like it's even more challenging with some of these specific cultures. And I was just wondering what the capabilities will be for the Armenian community.

>> DR. RIGOBERTO RODRIGUEZ: So I'm getting two questions. One is around kind of the -- where does the prevention and -- come into play. And then a second question around cultural competency in terms of staffing and practice with the Latinx, API, and Armenian community. So, La Tina, let me boomerang it over to you and see what your reflections are on those. And then I'm the list I have Barbara, Esiquio, and Hector. And we have till 3:15. Go for it, La Tina.

>> MARK KARMATZ: I have a question for you guys, please.

>> DR. RIGOBERTO RODRIGUEZ: Who is this speaking?

>> MARK KARMATZ: Mark Karmatz from Los Angeles [inaudible] right now, and they need to -- I need to be brought up to date as to what happened because I missed part of the meeting, I couldn't get in on time.

>> DR. RIGOBERTO RODRIGUEZ: Okay. Well, if you could just follow along with us and then I'll come back to you, Mark. Okay.

>> MARK KARMATZ: Okay.

>> DR. RIGOBERTO RODRIGUEZ: La Tina.

>> LA TINA JACKSON: So I'll speak a little bit, I'm also watching the chat. Some of the questions come up in the chat. So I just -- I can't emphasize enough that this is no longer a pilot, we proved it's possible. So it's become a regular part of the work that the HOME team does and one of the tools that we pull out

when we deem it's appropriate for the person that we're working with. As it relates to the questions on prevention, I can just tell you the department and the Homeless Initiative, as part of Measure H, are laser-focused on prevention. The department itself has invested in homeless prevention programs, including PH squared, which is preventing homelessness and promoting health. And that program is designed specifically for people who were formerly unhoused and now housed to make sure that they don't fall back into homelessness. And I know that much like Michelle's presentation is a follow-up and kind of a status update on a previous presentation that was given on the call center. I or Aubrey or Anthony will be coming back to this setting in the future meetings, and I can provide some more specifics on the prevention program and what the department has invested in, in terms of prevention, as well as the overall prevention strategies for Measure H. So I'm happy to do that.

In terms of staffing and cultural competency, I will say that diversity is always something that we look at whenever we're hiring for any program and making sure that the staff that we're hiring are reflective of the community -- communities that they serve. I do not have the specific breakdown of staffing for the HOME Program at this time, but it's certainly something that if the leadership team is interested in, in getting that information, I can certainly look into kind of what the breakdown is. And I will just advise that we pull in partners whenever -- well, my computer is doing some weird things. So I hope we don't lose you. We

pull in partners whenever necessary. Remember, we are part of the larger countywide system, and we certainly have Armenian and Armenian speaking clinicians countywide that we could tap into. If we had a situation where we needed to outreach someone and we were at a loss, at any moment Anthony or Aubrey could say, hey, you know, we need a little help here and we could work with our partners to try to make some inroads where we lack a language capacity or cultural capacity just to engage a particular person.

But I can just assure you in the hiring processes that we go through, we were always looking at diversity and looking at whether or not the people that we're hiring reflect the communities that we're serving, both in terms of their cultural background and their language capability.

>> DR. RIGOBERTO RODRIGUEZ: So this might be, again, a good topic that we can follow up on later on for that summit. I forgot to mention to folks that are joining us, the meeting today is for the CLT, the community leadership co-chairs. I believe others were able to join because the link was shared with others, but I'm going to privilege the folks who are part of the CLT, because it is a CLT meeting. Everyone else feel free to put your questions in the chat box, as well as, you know, observe today's meeting. And so I have -- next is Barbara Wilson followed by Esiquio and Hector. And we have about 10 more minutes to go. So Barbara.

>> BARBARA WILSON: Yes, good afternoon. Thank you all for this presentation. It really brings great clarity to me, and I don't want to talk too long. I did put some questions in the chat that if you could answer them, I'd appreciate it because we are seeing people that are chronically homeless and suffering from serious mental illness and the path to getting them into a consistent treatment process is very frustrating and I think what we're seeing is hope that I can take to family members and say, you guys are out there and how do we connect with you to make referrals? So thank you.

>> DR. RIGOBERTO RODRIGUEZ: Barbara, thank you for that comment. It seems like -- it seems like the last part of your comic views about how do we make sure that the linkage is clear and strong, is that correct?

>> BARBARA WILSON: Yes.

>> LA TINA JACKSON: So I'm going to confess a little bit to Anthony and Aubrey. I can just tell you that certainly in the -- in the pilot and beyond our pilot period, we've had individuals that we've engaged with that have had family members that were long looking for their loved ones. And as a consequence in this work, they were reunited with family. So I'm going to -- I don't know which one of you wants to speak to that, Anthony or Aubrey, but definitely we feel family is incredibly important. Yeah.

>> AUBREE LOVELACE: I'll take it, Anthony, if you're okay. So the first

part is for referrals and continuity, like La Tina mentioned, the LA-HOP is the best way to get a referral in for someone who's homeless, experiencing homelessness. I'm trying to add in our HOME referral and haven't quite figured out how to do it, so hopefully I can get it emailed out to everybody after this for the referral process. But like La Tina said, I think what we found is a vast majority of our individuals are not from Los Angeles. And so once we get them stabilized or families involved or close friends are involved in networks, we happily, and as much as we can engage with them, we do. I think it's usually critical. And we've found like mentioned individuals, you know, missing persons reports. And so we reconnect them that way, individuals from a variety of different states and family members who are thrilled and come out and see them and some have taken them home and have become their guardians, they can, you know, the conservator for them.

And so I think that that's, you know, not -- I think most of the families are trying and have run into so many barriers and roadblocks that they can't assist anymore, but a lot of them are hopeful and willing. So I think that's very important to us. So we get lots of family contacts come our way. All right, Anthony, can you --

>> ANTHONY RUFFIN: No, I think you summed it up well. I was thinking about what one particular person that we helped that even didn't live in this country and connected him to his family. So, yeah. Yeah, we definitely work

with families anytime we can.

>> LA TINA JACKSON: And I just will say, just add the point that we return to the public guardian for investigation, right, because that's the first step, not all petitions result in appointment of conservatorship. But at the point that we refer to the public guardian for an investigation, one of the first things that they do is to start a search, to find out, you know, if we have any information on that client's identity, any missing person reports, any, you know, family members and, you know, and as we're engaging, we're also looking up in his records and who's, you know, who the emergency contacts was, et cetera. So that piece is like from beginning to end. And the court certainly prefers, whenever possible, to have a family member appointed as conservator, where it's appropriate for that family member to do so and the family member is amenable to doing so.

>> DR. RIGOBERTO RODRIGUEZ: Thank you for those clarifications and those responses. So we have about nine minutes to go. And again, this is just the opening of this topic. I'll ask for volunteers who want to join the ad hoc team for further discussion that. We have five folks. If you could take about a minute each, just to let us know what your question or suggested is. And even if we're not able to answer all of them today, at least we will register the questions or comments, and then that will be the basis for us to do some follow-up work with you. So let's go up first with Esiquio.

>> ESIQUIO REYES: Hi. All people experiencing homelessness develop cognitive patterns based off of the parameters homelessness confines a person to. The lack of basic needs, coupled with the ability to adapt speeds up the reasoning process and the individual developed prior to becoming homeless. And because of this, whenever you do bring up the issue of prevention, can you focus more about the cognitive way in which you all are changing the person's perspective instead of just focusing on the housing part, because you're not going to stop a person from becoming homeless. That's just a given that that's just not going to be possible, but we can change a person's perspective as they're dealing with the streets in order to slow down the mental illnesses that come from an individual on the street. So I would like a more elaborate focus on that. Thank you.

>> DR. RIGOBERTO RODRIGUEZ: Esiquio, I duly noted it. And so it has to do with the cognitive processing and kind of the prevention work and support on that end. Let's go over to Hector. What's your question or suggestion or comment?

>> HECTOR RAMIREZ: Thank you. Can you hear me?

>> DR. RIGOBERTO RODRIGUEZ: Yes, we can. Go for it.

>> HECTOR RAMIREZ: No, definitely. You know, it's very interesting, it was very good to see this information. It's usually very difficult to access it,

especially as a consumer. So, you know, but I didn't really see here how it addresses the trauma that the people that the people that are on the streets live with and obtaining difficulty, particularly people from other countries, other states, people with disabilities, BIPOC communities. When we try to get services from the department, sometimes that experience is just horrific. And I say that as somebody who's been here 20 years, and I'm looking at my old clinic director, you know, who wasn't able to really help us. So, you know, I know that a lot of us while trying to get services, we have been abused, we have been re-traumatized, we have been threatened. We've had services -- I mean, just even the agency that sometimes we are forced to interact with it.

It almost feels like we get sometimes, you know, prostitize to other agencies for not being able to get the services that the department doesn't have funding for. And then when everything fails and we'd end up in the streets, this is there. I didn't see anything here about, you know, I really appreciated there could be a family reconnection, because it feels like the restoration process that happens with our system in both populations. And there's a reason for that is because its similarities are just continuous. There's absolutely no surprise, you know, that we're on the streets and in jails for those same reasons.

So I didn't hear anything about, you know, helping us restore from the trauma of the abuse, reducing stigma. If we have young ones watching this, this has got to be horrific. This is what could happen if you're not able to get the

services that you need from the department. And I think even the language sometimes that it was in this presentation from a person with a disability, from a consumer, it was very stigmatizing, dehumanizing. And I think seeing that as a consumer, knowing that we don't even have disability services was very -- very traumatizing, but it's part of what the department, you know, creates and is not aware of how you're continuing to hurting us even, you know, with these support services. Thank you.

>> DR. RIGOBERTO RODRIGUEZ: Thank you, Hector. And I think the kind of two or three themes that stood out to me in Hector's comments are around, you know, how does -- how does this team kind of really address and prevent the retraumatization, potentially, of folks. And then the access to service stood out to me in Hector's comment, particularly for, you know, queer, disabled, Black, Indigenous, and People of Color that are facing these other structural conditions, including stigma, right? So how do you navigate through issues in your practice? Thank you, Hector. And then let's go over to... I think, let me look at my list. I think it was Bianca. Go for it.

>> BIANCA GALLEGOS: Hi, can you hear me?

>> DR. RIGOBERTO RODRIGUEZ: Oh yeah. Well, I'm sorry, Bianca, my apologies. It was Pastor Nah, I just saw this. So it's Pastor Nah, followed by Bianca and then we'll end with Rick. My apologies, Bianca, sorry, sorry, sorry.

Pastor Nah.

>> PASTOR SEUNG NAH: I believe that conservatorship is what's needed for not only the homeless population, but also for the non-English population. I thought of something very useful on the DMH website. It's about public conservatorship. It's called "Helping your loved ones." I found this to be great material and I was wondering if we can translate this into major languages so that people who's in the LPS group, they can access this useful information and they can get useful information on the public guardianship. Thank you.

>> DR. RIGOBERTO RODRIGUEZ: Thank you, Pastor Nah. So it's really about translating those into other threshold languages, right? So I have Bianca followed by Rick. And Dr. Sherin, we'll end with you with your comments. La Tina, we won't have time for your responses, but at least those questions are getting registered and then we can set up another time for us to follow up and then come back to the CLT. So I have Bianca, Rick, and then ending with Dr. Sherin.

>> BIANCA GALLEGOS: Hi, can you hear me well?

>> DR. RIGOBERTO RODRIGUEZ: Yes, Bianca, go for it.

>> BIANCA GALLEGOS: Yes. So one of the questions or concerns I have, there's three of them, is when... when the calls are made, will random people with a scanner just like there's the possibility with the police force will hear

about the calls? Because we currently have organized crime responding to these calls because the response and arrival time is so long. And that happened to a friend. She already relayed her information, all the details of what happened. She relayed it to the detectives and she met with them and gave all her information to happen in the first week of April.

And also, the other concern is the immigrant population. Right now, one of my friends, and I met this person because I've worked with him briefly for two weeks and he was totally fine. Now, this person who's Thai and he's an immigrant, and now he's here working. Now, he's struggling with most recent current meth addiction. And right now I'm trying -- I'm helping her Thai friend who can communicate with him and with another -- with one of my roommates. And we're trying to coordinate an intervention. We're thinking about everything possible, because he's trying his best to remain sober and he feels like he was targeted from the job that he used to work at a restaurant because they have a lot of parties and they pass out a lot of drugs and he has never, ever touched that. So we need the Asian community also involved and making sure that this is a sort of safe place for the immigrant population.

The other part is, and the last part, is the LGBT community on West Hollywood is being targeted, especially the homeless because -- and the LGBT community, the homeless that are there are there for a purpose because they feel safe because it's a very gay-friendly community. And the communities that is

being targeted is a trans community. And they're doing it right now, some people are recording violent crimes on them, and it's being broadcasted on the web. And I already talked about it with -- shared this information on other public meetings. So I really hope that is not just a -- putting a bandaid on this situation. I know it's a lot of hard work, but also start gathering information on all the topics that I just brought up. Thank you.

>> DR. RIGOBERTO RODRIGUEZ: Thank you so much, Bianca, for alerting us to those urgent, urgent matters. I wrote all three down. I'll make sure that they get captured and sent over to the team here. Thank you.

>> PINKI MEHTA: Sorry, Rigo, this is Pinki. I'm going to step in. I know Rick still had his hand up, but we're running out of time. Do you mind if he puts it in the chat box?

>> DR. RIGOBERTO RODRIGUEZ: I was going to ask her for your indulgence, if we could get your question in the chat box. Is that okay?

>> PINKI MEHTA: Thank you.

>> DR. RIGOBERTO RODRIGUEZ: Rick, is that okay?

>> RICK PULIDO: Yeah, I was already ready to do that.

>> DR. RIGOBERTO RODRIGUEZ: Okay, gracias. Thank you. Thank you. So thank you to the team that is doing just an enormous, wonderful job.

Thank you for showing up. And then we'll follow up with you. If anybody wants to be part of this ad hoc group for dialogue, just put your name in the chat box. And let me turn it over now to Dr. Sherin, to share any comments. And perhaps, Dr. Sherin, you can segue us over to Mayor Darrell Steinberg. I know he's here today to share some of his observations on his stay here in LA. And so feel free to share your thoughts on what you just heard and then perhaps segue to an introduction with him. For Mayor Steinberg, what we want to do is I give you about 10, 15 minutes to share his response, and then we would open it up again for Q & A. So, Dr. Sherin.

>> DR. SHERIN: Yeah. Thanks, Rigo. I'm not going to say very much, because I think that Darrell's got limited time. I just got a text about that, and I'm really interested in hearing his kind of introductory thoughts. At the end of the day, this is a listening session. I mean, we are -- there are many different ideas about how to take a more humanitarian approach to the crises that we see in our streets. And that is the key. And there are a number of different folks at the state level who are trying to modify and are interested in modifying LPS law, which goes back, you know, roughly 50 years. And if that's going to happen, we would want to have as much wisdom about ways to do that and, you know, work with the community, all stakeholder groups to do it as well as possible. So, Darrell, I'm handing it over to you.

>> MAYOR DARRELL STEINBERG: Oh, well, thank you, Dr. Sherin, and

thank you to all the members of the task force here. This is a listening session and I certainly don't want to dominate in any way. I would rather spend the time that I do have, you know, to listen to you, because that's most important.

But for a few minutes, if that's all right, I want to begin by thanking Dr. Sherin and the Los Angeles mental health advocacy community for the incredible work that you're doing in Los Angeles. I will tell you that we know, I know how great the challenges are. I know how much unmet need there is. I know how the system is still broken and yet you are beginning to make some breakthroughs, which I think are very hopeful. The crisis residential campus that I saw in Supervisor Barger's district, which I know is one of multiple campuses around the county that you are building with MHSA money and SB-82 money and county general fund money, and other sources of funding, you are doing all that in the right way to provide mostly voluntary, compassionate crisis care for people that isn't warehousing, that isn't -- that isn't just stop gap, but is an essential part of what we have all fought for so many years. And that is a decent and effective continuum of care that allows people to, who have fallen on the hardest of hard times to get the help they need to stabilize, to get housed, to get whatever degree of wraparound they need, and then to be able to move out of homelessness or out of the cycle of homelessness and jail and the downward spiral that so many live and suffer from.

And, you know, our great challenge, our great challenge in Los Angeles,

our great challenge in Sacramento, the challenge at the state really is how to scale what we know works, because even with all I saw in Los Angeles, under Dr. Sherin's leadership here, it's still a bit of a drop in the so-called proverbial bucket in terms of the need that is out there and the numbers of people who are chronically homeless and who are suffering. And so, how do we fix the system? How do we fix the system? There isn't one answer to that question, but I do have observations that I do think lead to solutions. We have got to end the terrible fragmentation of our mental health system.

Either we do single payer for mental health, which by the way I would vote for. Or we do what you're doing in Los Angeles and what Orange County has even taken slightly a step farther. And that is we create collaborative funding models of private insurers, health plans, providers, the county, the cities, and the individual that is served either in crisis or outside of crisis. It doesn't matter what their insurance is or whether they have insurance. The campus is payment agnostic, the adults in the back room figure out the payment, not the family and not the client. We've got to create a more integrated system.

And whether we use this -- whether we seek to change the state law to say, you know, if you're a health provider or a health plan and you want to provide Medi-Cal or Medicaid to around mental health, then you've got to be part of a comprehensive, integrated funding strategy, otherwise you don't get the contract. Practical stuff, but why not?

And so a single system that doesn't confuse well informed people about how to get help is, you know, the first order of business, we always need more money, but I will tell you as the guy who did the millionaires tax or led on the millionaires tax because I didn't do anything. I was privileged to lead with a lot of people, that we always need more money, but money's not our biggest problem now. We've got money, at least for now. So I'm this one time. It's how we use the money, and whether or not we are producing the kind of relief and results that are a part of what we expect in a compassionate society.

How do we create the incentives to create a more coherent system that is premised on the needs of the person, of the consumer, rather than the system? I subscribe to the belief that one of our fundamental problems around mental health in society is that we as a society are not required, I'm not talking about LPS reform here, I'll get to that in a moment. But more fundamentally that we as a society, that we as governments, we are not required to provide any type or level of mental health treatment or services to anybody. We are not. Now that's, I know a bit of a generalization, but it's largely true. You can, you know, county can match as much Medicaid money as it wants, you know, put forward matching money as much as it wants to draw down federal money.

Jon Sherin, you go to the beach every other Thursday if you wanted to do so, and he doesn't. I mean, you know, you don't have to work so hard on all this stuff that the law does not require you to do so. It takes extra leadership like the

kind you have in Los Angeles to even begin to breakthrough. But nothing is required. And until we have some form of a legal obligation for the government to provide housing and services to people, we're going to continue to do bottom up and struggle to meet the need, because when society says something matters, we generally require it. We require a free public education for all our kids and for our communities to build public schools. We require that we provide services through the regional centers to people with developmental disabilities. Why not mental health?

We say when it comes to climate, that we must, not may, we must replace fossil fuels by ever increasing percentages with renewable energy. And by the way, that market's changed now, and people are responding to that, and we're making greater progress than we ever have before housing, mental health services. Man, you're lucky if you have a John Sherin, not every time he does and not every community does. And we don't have the kind of leadership we have that demonstrated on this call today. We have to require housing, that kind of services and that needs public policy that needs to be changed.

And then you get to the LPS law itself. And, you know, the law is so fraught with history and trauma that it's understandable in a way why it's hard to have a real conversation about modernizing it, for example, to redefine what grave disability means as John has talked about and you've talked about safety in the community. It's hard to have that conversation in the legislature because it

invokes memories of state hospitals and all the bad that that meant for civil liberty, civil rights and the treatment of people. But we've got to have that conversation in some form because I know one thing, and you know what, living on the street in any form for any length of time is inhumane, it's unsafe and it's unhealthy. And that adds a more important and questions of individual autonomy, in my opinion.

We know most people will come in and get the help if we do the right thing by providing the housing and the services, and we build those trusting relationships. And so, to me, the question of LPS reform is relevant, but it should not be the -- it should not be the lead item in the debate, because the first obligation is on the government to do what it's not doing to scale. And so I would -- I think, and I proposed this in my city, that maybe a better proxy for a mandatory treatment or conservatorship is that when someone is offered several dignified places to live that meets their needs, that they have to say yes to one of them. And if they don't, what is the remedy? Not crime, not civil penalties, none of that. You simply can't camp where you're camping now because of the public health and safety. I think we have to have the courage to have the big, broad conversation and step back from the complexities of it and say that the law must support the idea that as a society, people live indoors and get the help they need. If you start there, everything else follows because if that's the law, then all those cities that you struggle with to try to bring into the fold, they got to come into the

fold and work with you and commit their money to your money and move towards production.

There's a lot we can accomplish here. This is the moment because people's attention or people are paying attention, some for negative reasons, because you know, the voting public is tired of homelessness, they've got compassion fatigue. Well, I think we've got to turn that compassion fatigue into effective compassion. And that's what we can do together. Dr. Sherin's idea of simply redefining grave disability to be able to do the assertive, compassionate outreach out on the street and only at the very end, if somebody after many months is unwilling to take advantage of that, maybe then you apply, you know, something that's a little bit firmer to try to get them the help that they need, as opposed to the emergency rooms, this, you know, the hospitals and all of that rigmarole that is just inhumane and ineffective, and connecting that kind of law change with the campuses that you're building throughout Los Angeles County. We can't give up here, but we have to acknowledge that at least, I believe we have to acknowledge that living on the street in any form is not acceptable. It's not acceptable. It's -- it's wrong. And it's not the fault of the individual. Our systems, our laws, and funding. Our insistence must be to provide something better for people to scale. That's it.

Been at this for a long time. It's a life's -- lifetime of work and will continue to be. We have the Mental Health Services Act. We've got, you know, new

Biden money, infrastructure money. We may have CalAIM. We're going to have all kinds of opportunities. It's all about what we do with it together and insist on the change that is consistent with our values and our humanity. Sorry, that's it.

>> DR. RIGOBERTO RODRIGUEZ: Mayor Steinberg, thank you so much for sharing your reflections. I'm going to just highlight what I heard and then turn it over to Dr. Sherin; I know he has a hand up. I'm going to remind folks that again, we have certain participation principles and one of those clearly is that we offer respect to anyone that's in our space. And so I'm going to make sure that we abide by that. So what I thought is that, you know, we have to have a premise that living on the streets is just not acceptable, right?

>> MAYOR DARRELL STEINBERG: Right.

>> DR. RIGOBERTO RODRIGUEZ: And then I heard you mention that we need an integrated system with comprehensive -- with a comprehensive funding model, so that we're able to scale up those integrated services that we need to establish a legal obligation for government and society to serve the mental health, health, and housing needs of our communities. That LPS's reform has been saddled with a history of a stigma, but we do need to transition to being able to offer multiple options that individuals who are houseless can say yes to and without criminalizing their houselessness.

>> MAYOR DARRELL STEINBERG: Right.

>> DR. RIGOBERTO RODRIGUEZ: And then -- so those are the key points that I got. And Dr. Sherin, any comments before I open it up?

>> DR. SHERIN: Just a couple, I mean, first, Darrel, thanks for taking some time and thanks for your courage, which is longstanding and kind of provoking conversations and solutions. I mean, one thing I will say is that we, you know, we are warehousing people in the streets, in the jails, and for those who are right now having LPS conserved, they're being warehoused in hospitals for months and months and months. And this new pilot is about not doing that. We don't think of a chronic condition of living in the streets. Some of these people for, you know, years and years should end up in the hospital when we can try to do it in the outpatient sector, save money, save space, and be less traumatic to the individual.

I do want to make a quick comment, Darrell, you said how we use the money and you can imagine what I'm going to say. How are we able to use the money? Are we permitted to use the money? And then how are we accountable? And we want to be accountable, I would say, to achieving outcomes, not processed and fenced-in money. We want to achieve outcomes for people. And your comment about orange county and what they're doing around parody and bringing all the different funders together is genius, and we're going to explore that. And I would actually encourage people in this whole stakeholder set to look at the "Be Well Model" in Orange County, which brings in resources beyond the

specialty mental health plan from a variety of other sources. That's going to be critical to fixing the system.

>> DR. RIGOBERTO RODRIGUEZ: Mayor Steinberg, any reflections on that?

>> MAYOR DARRELL STEINBERG: Well, I agree with everything Dr. Sherin just said. And, yes, one of the other discussions we are having in our circles that we have to broaden now is what we call the MHSA Prop 63 refresh, which is how do we make that money even more effective? It's $2.5 billion or so a year, and it can be, on its own it's a lot of money. But certainly matched with the CalAIM, federal drawdown, the federal waivers, the health plan money, all the other resources. It can be the fuel, clean fuel by the way, the fuel that really allows us to achieve so much more here. And I would like to see more of that money spent on the people who are most chronically ill and living on the streets. That's -- that was, you go back to 2004 when we did this initiative, that's exactly what we campaigned on. We sold it as a homeless initiative.

Now, the Full Service Partnership model is exactly the right philosophy, but there is a question about whether or not it's being focused enough on the people who are most chronically ill and at risk of early death, frankly. And I agreed with Jon that we ought to move to an outcome based model, because if one of the outcomes is the numbers of chronically homeless people with severely mental

illness you get off the streets, then the incentive is going to be to spend more of that money on that category. It's tricky because there are a lot of good programs that maybe don't meet that definition that then might not get funded, that it may be preventing people from becoming homeless. So we have to figure -- we have to be bold, but we also have to think about unintended consequences upfront and address them.

>> DR. RIGOBERTO RODRIGUEZ: Thank you. So I have Marcus followed by Esiquio, Hector, and then there's a 323 number. And I'm going to ask if that when we get there, that's a, you know, CLT member. So, Marcus, go ahead.

>> MARCUS HAILEY: Hi, I actually agree with a lot of what Mr. Steinberg said. But I also want to acknowledge another big problem. Here in California, one of the huge caveats of our homeless dilemma is that a lot of our homeless actually come from other areas. You know, along with what Mr. Steinberg said, I feel that there should be an incentive to treat people who are from the area itself before those who come from the other areas and actually seek to stipend awful lot of the services, which are often here. And it's one of the unspoken problems. A lot of people come to California as homeless people for the weather because it's easier to be homeless in the weather, and also for the abundance of social services also here. So restricting services to people who have been residents here for a certain amount of time, I feel would be a twofold thing in actually

slowing the process of coming from other areas as homeless and also in treating people who are from the area.

>> DR. RIGOBERTO RODRIGUEZ: Got it, Marcus. So let me take two more comments and then we'll circle back with you, Mayor Steinberg. I have Esiquio, followed by Hector.

>> ESIQUIO REYES: My question was, or I was wanting to know more about funding part because I've looked into many avenues in order to try to help the homeless based off of the experience that I gained by dealing with it for over 10 years, but no services are helping in a way in which help prevent a mental illness from developing on the streets right now. So I was wanting to find out how an individual instead of just a corporation or a nonprofit can come across the funding. Sorry.

>> DR. RIGOBERTO RODRIGUEZ: Okay. So not only how do organizations receive funds, but how do individuals themselves who are houseless receive funds, yes? Yes. Okay.

>> ESIQUIO REYES: No, how does a person that has the knowledge on how to prevent a mental illness from developing within a certain population receive funding so that they can actually venture and try to help sustain stuff like that for the community?

>> DR. RIGOBERTO RODRIGUEZ: Dr. Sherin, did you want to respond to

any of these first two?

>> DR. SHERIN: Well, I mean, I'm not sure it would be exactly what you're looking for, but the contracted agencies around the county and the Department of Mental Health are really, I mean, at some level, desperate for help. So we look into hire people, so really the contractors to do the work. And as you probably know, with the help of Darrell, we got SB 803 pass. So we're, which is a peer certification bill. We're looking to expand our workforce with a significant number of people who have lived experience, which is as valuable or more valuable to the engagement process as anything. So look for a job and apply one. We'd love to have you and other people come and help carry the water with us.

>> DR. RIGOBERTO RODRIGUEZ: And then on the first question with respect to folks from out of state coming in, any thoughts on that question?

>> MAYOR DARRELL STEINBERG: Well, that's a hard one. I mean, it is a reality. I think, respectfully, it's an overstated reality. The majority of people who become unsheltered in our communities have fallen on hard times in our communities. And yet what it really speaks to your question is that when I talk about a right to housing or a right of any kind, this needs to be a national policy, because even a state as large as California offering more than others than other states, you know, I guess does put us at that kind of a disadvantage, even though I think the argument is overstated. But yeah, we have a -- it's hard

because I'm -- I believe a human being is a human being is a human being, but it's hard enough to help the people that are unsheltered in our state much less taking, you know, new folks in. It's a dilemma, but it speaks to the need for a national policy.

>> DR. RIGOBERTO RODRIGUEZ: So that regardless of where the individual is at, there are resources that those states can draw upon.

>> MAYOR DARRELL STEINBERG: That's right. That's right.

>> DR. RIGOBERTO RODRIGUEZ: So then I have -- we're going to go to Hector, Carmen, and Cody. And then after Cody, so we'll summarize and then ask Mayor Steinberg and Dr. Sherin to respond. So go ahead, Hector, with your question.

>> HECTOR RAMIREZ: Thank you. Nice to see you, Mayor Sternberg. Congratulations. You've got to be the first host of this group before the LA Mayor, Eric Garcetti. So --

>> MAYOR DARRELL STEINBERG: Really?

Don't tell him that.

>> HECTOR RAMIREZ: Oh, believe me. I think he knows that. You know, I'm glad that this conversation is being spoken here. I'm still a little confused of the setting or the intent of this conversation. I follow Sacramento news very well.

I attend your board meetings every once in a while. So I know the controversy and, you know, the difficulties that your community faces are somewhat similar to what LA, but incomparable given the fact that L.A. County is so big, so diverse and Sacramento is where you have access to a lot of politicians so you're able to enact policies at a different scale that have different results than what we see in large counties like L.A. County. But I think I over -- as a consumer of L.A. County DMH as a beneficiary, I wanted to kind of just speak to the fact that I'm a little bit scared to speak to you to have the department have our co-chair speak to you. Because I know that on this topic, retaliation harassment does occur, particularly to our cultural communities. You mentioned the MHSA, which has benefited and transformed mental health across California, not necessarily for queer disabled of people of color, which was originally intended to serve. The lack of oversight and accountability has meant that mental health services, not just in L.A. County, but across California has become a racialized type of care where the type of services that you get, especially your community, really depends on the color of your skin, your sexual orientation, your disability status.

So I worry that having this type of conversation with my peers, without them necessarily having the context between the confirmation and even the basic information, which we've never really had despite asking for it could perhaps signal or give a wrong side, that we are endorsing the proposals that both you are proposing in Sacramento at the state level, or even that this could

somehow legitimize. I know you and your Stanford Institute are involved in [Inaudible] let's press this. So I really wanted to have some clarity as to what it is that we're being asked to do. Are we here to endorse the work that our Sacramento. Is the county really trying to engage us? And how can we do it so that we can actually receive it?

>> DR. RIGOBERTO RODRIGUEZ: Hector, I'm not sure --

>> HECTOR RAMIREZ: I wanted to have some clarity as to what it is that we're being asked to do. Are we here to endorse Sacramento and is the county trying to engage us?

And how do we do it so we can actually --

>> DR. RIGOBERTO RODRIGUEZ: Okay. There's just a number of things there from the MHSA being racialized care to contending that this is a political stunt. So I'm going to --

>> HECTOR RAMIREZ: I apologize. As a person with a disability, this is how I speak. I'm sorry it's confusing.

>> MAYOR DARRELL STEINBERG: I understood it. I understood it. I understood it. And thank you for -- thank you for your passion and for articulating your concerns. I didn't come on the call today to ask you to endorse my Sacramento proposal about a right to housing. I just meant, you know, just

because it's -- I believe there needs to be some compulsion for the government to produce. That's what I believe. And I'm trying one form of that.

Look, the only way we're going to make progress is if we listen to each other. And that's so true of the legislature as well, you know, the debate about LPS reform, for example, I wouldn't even call it debate because there's such a histories and such fear that it's hard to have a conversation. And yet, where are we if we are not willing to talk to each other about how to alleviate the suffering of people that are on our streets and the suffering of people who aren't homeless, but who are -- who have less than good lives because they aren't getting the help that they need? That's all this is. And, you know, laws that have been on the books for decades at a minimum ought to be reviewed and updated because times change.

And I repeat what I said earlier. If we start from the acknowledgement, I don't think we acknowledge enough that the untold suffering is in part a result of -- well, that we start -- we start from the place that says under no circumstances is it okay for the health and safety of the individual and the dignity of the individual to be living unsheltered. We start there. I think we can make progress on the most difficult and controversial issues. I believe that.

>> DR. RIGOBERTO RODRIGUEZ: I have Carmen followed by Cody. Can we hear your thoughts first? Go ahead.

>> CARMEN PEREZ: Yes. Hi, Mayor Steinberg. I'm actually from Sacramento. I'm actually here visiting family. So it's nice to see you being part of --

>> MAYOR DARRELL STEINBERG: Nice to hear you, Carmen.

>> CARMEN PEREZ: And my question goes back to, first, 31 billion surplus that we have, and we continue to have surplus, thank God, for you guys do such great work over there, as well as certain bills like SB 805 and SB 221. And I guess the SBA 805 is the pay parity when it comes to mental health and SB 221 is that it requires health insurers across the state to reduce wait times for mental health care. I'm wondering how can we work when these bills get passed? How can we work better to make sure that these bills get implemented in an appropriate manner? Because we get these bills that are passed, there's no real monitoring or implementation of it. So those are my questions.

>> MAYOR DARRELL STEINBERG: 855 is the parity -- I think it's 855, the parity bill.

>> CARMEN PEREZ: Yeah.

>> MAYOR DARRELL STEINBERG: And as you know, just begun to go into effect. And so I do think it is incumbent upon first the Newsom administration to oversee that bill and make sure that they prosecute any violations early so that the message is sent that they, and we, are serious about

real parity. Oversight is very important, but I think it's more than oversight in the instance of our mental health system. I think it is an insistence that we match this new money with systems change, new money and systems change. Systems change as an academic exercise without money will not help people. Loads of money without confronting what's broken about a fragmented system and trying to do something about it, and CalAIM by the way is a decent start from the administration. What LA's doing with their campus based models would be what Orange County is doing with their campus based models and bringing in the private insurers.

These are the beginnings of dealing with this disjointed fragmented system that prevents people from getting care. And that's where the focus needs to be. What laws need to be put in place to create either in function or in reality, a single integrated mental health system for people, regardless of their status, regardless of their insurance or lack thereof.

>> CARMEN PEREZ: Yeah. Thank you. The problem that happens is, it does get implemented, but there's no real action behind it, like the pay parity. So I just -- I'm hoping that things can get implemented quicker and more efficiently.

>> MAYOR DARRELL STEINBERG: So do I. I'm not in the legislature anymore, by the way. I'm not -- I'm just the mayor of Sacramento, so I no longer have that legislative gavel, but, you know, I still have a voice. And we have the

Steinberg Institute with our team Maggie Merritt and our great legislative team that's out in the capital every day on behalf of the L.A. County and the State of California fighting for a better system.

>> CARMEN PEREZ: Thank you.

>> DR. RIGOBERTO RODRIGUEZ: I have Cody followed by Wendy and then given the time constraints we'll end with Wendy and then perhaps mayor Steinberg and Dr. Sherin can offer final comments. So Cody followed by Wendy.

[No response].

Cody, I think you're muted.

[No response].

Cody. So let's go to Wendy first and then I'll circle back with Cody's. Wendy, are you ready?

>> WENDY CABIL: Yes, thank you. Thank you. Nice to meet you, Mayor Steinberg.

>> MAYOR DARRELL STEINBERG: Nice to meet you.

>> WENDY CABIL: Thank you. And I'm the co-chair for the Black and African Heritage Underserved Cultural Community group, and as well as a client stakeholder. And I've been with the department for 12 years. I'm liking what I'm

hearing and I want to support what I'm hearing. But I know it's a process. And I like what I recently heard. You said about having honest, open dialogue and that's necessary. So we can have a clear assessment of where we are in order to move forward with clarity. And part of what bothers me is that not everyone is on the same page in DMH, and this is not my first time sharing it. You should share first time -- hearing me say this and I'm willing to work with them. And I will be meeting with Pinki, hopefully before the year ends to start that process. However, there's a great disconnect from what DMH headquarters does and what all the service -- what all the service area does.

I've been preaching hell, you know, with this communication pipeline that's a bottleneck because whatever, you know, I hear as a leader now that I'm in this leadership position for just a year, it doesn't trickle down to the -- to our service area SALTs. Well, they call them Service Area Leadership Teams. It's on paper, but it's not being practiced and I can no longer be silent. And so in order for us to move forward, we have to be realistic of what's really going on and what's really not working. I don't mind tooting the horn when something great is happening, but I'm not trying to sugarcoat anything either and overlook the gaps that are still growing in disproportion and with great disparity as we just experienced it as a nation. So, you know, enough already. Let's get the job done. Let's get together and let's work together and let's get the job done. And if you, if there's an ad hoc team for peers, I want to be on it.

>> DR. RIGOBERTO RODRIGUEZ: Okay. Thank you.

>> WENDY CABIL: Thank you.

>> DR. RIGOBERTO RODRIGUEZ: Wendy, if you can allow me to see what Cody wants to say, and then we'll circle back with both our speak -- you know, with our guests around that topic.

>> CODY HANABLE: Does it work?

>> DR. RIGOBERTO RODRIGUEZ: Cody, any final sound -- Yeah, go ahead, Cody.

>> CODY HANABLE: Okay, good. Sorry about that. Yeah. Thank you, Mr. Steinberg, for joining us. And I just want to be very quick for my comments and kind of observations. So the push to a universal system of California, yeah, it's desperately needed in terms of being able to create more consistency across the counties and being able to move more freely, too, because as you've like experienced, like for those that are homeless, they're moving county to county and services take a long time to move with them. The one thing that I was kind of observing those, that the incentives for effective service providers to remain within the public sector and providing services does not outcompete the amount of work that is required under providers or agencies and nonprofits that work with Medi-Cal. The providers themselves are spending more time with paperwork than actually providing services face-to-face. And with all these disconnects

between requirements from county, federal, and state level, there's -- it all adds up. And so is there a better way to hold these agencies accountable to document and make sure that they're doing their job, that doesn't put the burden on the providers taking away time from doing that one-on-one service?

>> DR. RIGOBERTO RODRIGUEZ: Thank you, Cody. Mayor Steinberg and then Dr. Sherin, feel free to comment on both.

>> MAYOR DARRELL STEINBERG: I'll let Dr. Sherin finish and conclude, but let me just say thank you again for the dialogue. I look forward to many more dialogues. You know, first of all, the previous speaker talked about being impatient. I am so impatient, just like you, and just like all of us, because change is too slow. And yet we have had victories because we've been impatient. We've had real victories because we've been impatient. We got the Mental Health Services Act because we were impatient and went to the ballot and didn't want to wait for the legislature. We got major parity victories because we were impatient and took the fight to the insurance companies. We got no place like HOME and billions of dollars for housing because we were impatient with the lack of a housing strategy within the MHSA. We got peer review because we were impatient after 20 years of governors saying, no, it would be too expensive. And so we have to just continue to be impatient as a motive and a strategy to achieve more and help more people.

The second question is, I think it's Jon Sherin's idea really, you know, that I've subscribed to actually for a long time as well that we ought to be judging the systems, not based on the process, but on the outcomes. Government doesn't do very well with that. Government has never figured out how to translate consistent funding with the outcomes that it expects and that the public expects when a big new law is celebrated after it passes. And maybe we have a chance now with the Mental Health Services Act refresh it in a way that focuses on outcomes. You get more money if you are actually reducing the numbers and the percentages of chronically homeless people who live with serious mental illness. You get more money if you're reducing out of home placements for kids because investing in family prevention and early intervention. That's our next great frontier. I think we can make some progress. Thank you. Jon.

>> DR. SHERIN: Yeah. Just to dovetail on that, I would agree and, you know, the comment, I believe it was Cody, about paperwork and what I say, taking care of the auditor instead of the human beings that we're here to care for is primary. And, Darrell, I remember one of the very first times I met you, I was talking about this pretty loudly at UCLA and it continues. And it's worse as well. It's bad everywhere. And insurance companies, whether it's, you know, the mental health plan of L.A. County or whether it's the VA, beat our frontline staff to pieces to get processes dealt with and to get boxes checked. And it steals the time, the energy and, frankly, the soul for the people who are just trying to do the

work. And that has to be fixed. And one of the ways to fix it is what I believe we're working on with MHSA refresh. And that is to say, get us the outcomes, demonstrate you got the outcomes. I don't care how you spend the $20,000 to get the person the outcome, get the outcome. Why can't we go there instead of this fee for service kind of process, we have this mechanism that just get -- that steals from actually our core mission.

I want to say to this group, you are the CLT, you are the co-chairs of various stakeholder groups across L.A. County, and you're empowered to come in and to share what you see and what you hear in your different groups and to bring it back to this centralized entity. So I know it's going to take a lot of us to get there, but the department has, I mean, we have invested so much more time and energy and money into stakeholder processes to make it genuine.

And I'd like to think that because individuals are out in their service area or in their underserved community listening and engaging with the rest of their group, that they can come back, tell us what we're hearing, and then also go back and explain what's going on. It's an iterative process, but the disconnect between service areas and CLT or the centralized group is just upsetting to me. I don't know what we need to do to fix it. We have to fix it.

Yeah, impatient is a good word for a lot of us. And I... It's hard to express my level of impatience and I talk about it all the time and I feel for the staff that

have to deal with me because I am impatient. And I think we have to be relentless and persistent and strong in order to move this archaic system that has to get fixed, or we're going to continue to see humanitarian crises across the lifespan and inequity.

>> DR. RIGOBERTO RODRIGUEZ: Well thank you, Dr. Sherin, Mayor Steinberg. Thank you so much for being here and also to members of the CLT and guests who joined us. It is now four o'clock and I just want to end by saying that in terms of next steps, if you want to be part of a dialogue, thank you mayor Steinberg for joining us. Feel free to stay with us for another three hours. Just kidding. [Laughter]. So if you want to be in the dialogue around the LPS home presentation that you heard, just put your name in the chat box. Some of you already did. That'll give us a clue as to who to contact. The other is our next CLT quarterly meeting will be at the end of January. We're looking at Dr. Sherin's calendar and I will send out the date fairly soon.

And then finally to the last point that Dr. Sherin mentioned that this is why we want to select the right topics. And if one of those topics is a disconnect topic that Wendy brought up, then those are the topics that need to be brought to us. And so please contact Pinki directly where we can then identify those key topics. And then just to end, I know Bernice is here. Bernice, at the beginning, we did share some words of solidarity and support in light of the news that we got about Sunnie. And so we are -- our heart is with you and also with Sunnie's spirit. And

then Pinki will be following up with you Bernice to make sure that we send out a link on anything that we can do to support Sunnie's return. So thank you, everyone.

>> BERNICE MASCHER: Thank you so much.

>> DR. RIGOBERTO RODRIGUEZ: I'm sorry, was that Bernice?

>> BERNICE MASCHER: Yeah, I was just saying thank you so much. I'm sorry I was late. I was talking to a funeral home. So a little bit of juggling now. So thank you. I appreciate the support. And it's good that the work continues.

>> DR. RIGOBERTO RODRIGUEZ: Bernice, our heart is with you and thank you for sharing your words. So thank you, everyone. Have a great rest of your week and celebration for those who celebrate, and those who choose to use a different approach to these festival days, be safe and healthy. Thank you.

>> DR. SHERIN: Bye-bye. Thank you.

>> DR. RIGOBERTO RODRIGUEZ: Bye-bye.

[Meeting Adjourned at 4:02]