

**Los Angeles County
Department of Mental Health
Service Area Advisory Committee 5
11303 W. Washington Boulevard, Suite 200
Los Angeles CA 90066**

February 25, 2015

Christina R. Ghaly, MD
Director of Health Care Integration
Chief Executive Office
Kenneth Hahn Hall of Administration
500 W. Temple Street, Room 726
Los Angeles, CA 90012

Dear Dr. Ghaly,

The Service Area Advisory Committee (SAAC) for Service Area (SA) 5, West Los Angeles, appreciates the opportunity provided by the Board of Supervisors to participate in the stakeholder/public participation process and to have our input considered in the report on the proposed consolidation of the Departments of Health Services, Public Health and Mental Health into a single integrated agency.

Part 1: History of the SAACs

One of the very first acts of the newly formed Department of Mental Health (DMH) in 1978 was to establish the five Regional Community Liaison Committees (RCLCs), envisioned to serve as the community arm of DMH. Beginning on October 27, 1978 the RCLCs provided local providers and consumers a means to have their input heard with regard to DMH programs, activities, and goals.

In 1985 the Board of Supervisors reexamined the delivery of services to the growing and increasingly diverse population and reapportioned the five Regions into eight SAs. To increase planning among other county service agencies the SA boundaries were reconfigured in 1994 to what they are today. The RCLCs were transformed into the SAACs and charged with four primary functions:

- as a local planning body to partner and gather community input, analyze information, prioritize programs, and integrate services tailored to the service area;
- as an advisory body to provide DMH with ongoing feedback on existing or proposed programs including modification of programs, policies, and budgets for the service area;
- as an information body to provide DMH with a vehicle to support and assist with the coordination of mental health programs and services with the service area;
- as a networking and advocacy body.

Each individual and organization associated with a SAAC are valued volunteers, an important part of the DMH stakeholder engagement system, and counted on to provide feedback and advise on how well the DMH care system is operating.

Part 2: The Unique Collaborations and Stakeholders of SAAC-5

SA-5 consists of 5 cities, Beverly Hills, Culver City, portions of Los Angeles, Malibu and Santa Monica plus Marina del Rey, which is an unincorporated portion of Los Angeles County. The SA is represented by three members of the Board of Supervisors, Don Knabe, Mark Ridley-Thomas, and Sheila Kuehl.

SA5 is often perceived as rich and having less problems because of pockets of wealth. The truth is one of the highest suicide rates in the county is in West LA, found within the white male demographic. We have pockets of poverty and especially homelessness all the way from Malibu at the top of our service area through the beach areas to LAX at the South and from the ocean to La Cienega Boulevard. The latest homeless figures available are from 2013 but indicate 32.7% increase in homelessness over 2011. The total homeless in SA-5 in 2013 was 4,662. All of the demographics for SA-5 can be found at:

http://psbqi.dmh.lacounty.gov/SA/Reports/SA5/SA5_Demography_and_ConsumersServed_FY2011=2012.pdf

Included in SA-5 are one directly operated mental health center, 7 contracted agencies for people 18 and over, and 7 for ages under 21 and family. There is one agency for TAY/Youth only and 1 for older adults only. For veterans there are 2 programs for outreach and linkage. For Ethnic/Language specific there is one agency serving Asian Pacific Islanders (API). For short-term or crisis housing there are 2 crisis residential programs and 3 transitional shelters (1 for women and all three for homeless adults). For Peer-Run programs there are 3 for adults and 2 Wellness Centers for adults. For crisis services there is one psychiatric urgent care center (currently being relocated); 2 psychiatric hospitals (1 for 18+ only) and 1 Psychiatric Evaluation Team (PET). There is a full range of Field-based Treatment (FSP/FCCS) of which 2 are for ages under 18; 2 for TAY; 6 for adults and 3 for older adults. DCFS/Probation has 3 co-located programs. There are also programs that are not contracted with DMH who are working with specific populations and collaborate with many other services.

In August, 2014, as part of the Mental Health Services Act (MHSA) 3-year Budget Planning process, SAAC-5 identified 3 key priority areas where there are gaps in mental health services:

- Prevention and Early Intervention for Young Children and their Families
- Supportive Housing
- Homelessness

And 3 issues that span all 3 priority areas above and impact the communities ability to meet its needs:

- Domestic Violence
- Cross-training and Coordination amongst health, mental health, substance abuse and public programs (DCFS, DPSS, etc.) regarding interrelated and exacerbating mental health issues among individuals, family members, and the community
- Lost Populations of individuals and communities that are underserved by current systems in these priority areas.

SAAC-5 has been actively working to build additional collaborations within our community, at every level, and are pleased to be part of the demonstrated successful outcomes from INN1, the Innovation Program funded by the MHSA, to learn about and explore creative and effective approaches that can be applied to the integration of mental health, physical health, and substance abuse services for uninsured, homeless, and underrepresented populations.

Part 3: Concerns with the existing Board of Supervisor's Motion to Consolidate the Departments of Health Services, Public Health and Mental Health into a single integrated department.

The plan must include a significant improvement in the delivery of services or benefits to our consumers.

The plan must have a clearly defined budget. It is obvious that funds will be needed to set up a new level of administration oversight and the shifting of many areas of reporting and services. The funds must come from somewhere. How the integration will affect the budgets of each of the departments must be a transparent process.

The plan must include provisions for preserving crucial, hard-earned improvements in the mental health system. Mental health services aren't just about relieving symptoms and suffering. They are about rebuilding people's lives.

The plan must have a robust inclusion of stakeholders in the integration process. We need to predict how these plans will affect the individuals living in our community.

The plan must build on the current DMH collaborations and partnerships in these three social systems:

- The criminal justice system is forging collaborations with mental health to assist the large numbers of people being released and diverted from prison and jail.
- The homeless system has forged strong partnerships with mental health.
- The child welfare system also turns to mental health for help.

These three areas of growing collaboration with DMH are crucial to our community. In each area there is a respect for and understanding of mental health's journey and abilities. If any of these three areas is damaged by the proposed integration it will be a serious loss.

The plan must include these three components:

- **Welcoming and Engagement.** To serve people who are stigmatized and rejected by our community we need to be able to form trusting, productive relationships with people that "normal" society can't. Serious efforts must be made to examine our own prejudices to create welcoming cultures and programs to meet people where they're at (even if that is indigent, untrusting, poorly motivated, poorly self-coordinating, and even self-destructive). Mental Health has built outreach and engagement, peer greeters, ambassadors, and bridgers, system navigators, case managers, cultural partnerships and programs, motivational enhancement, self-help, family partners, and advocacy into our system.
- **Commitment to Improving** whole lives, not just illnesses. Treating symptoms doesn't work. People need to build protective factors (like finances, homes, families, purpose in life, cultural and spiritual connections) to stabilize their mental illnesses and achieve mental health. Social determinants of mental health must be directly addressed. Trauma informed care addresses contributing life factors to illnesses.
- **Collaborative Care.** The standard professionally driven care model leads to enormous numbers of drop-outs and high rates of non-compliance with "doctor's orders", especially for chronic illnesses, and especially for mental illnesses and substance abuse. People must be actively involved in their own care.

The plan must have as its goal "Equity for All", and must address the needs of the underserved communities, as well as the culturally competent and linguistically appropriate services needed to reduce stigma and disparity.

Part 4: Support for the potential benefits to all the citizens of LA County

We support the Planning Principles as adopted by the DMH System Leadership Team on January 21, 2015 and as amended and adopted by the Mental Health Commission on January 23, 2015.

We support a planning model in which each health department would

- maintain its own director and budget
- report by department to the Board of Supervisors
- be held accountable to fulfill the agreed upon objectives

We support a planning model that ensures citizen, professional, and faith-based involvement at all stages of any planning process. Representatives of the Mental Health and Public Health Commission should be included in the preparation of the plan to the Board of Supervisors, working directly and along with the Interim Chief Executive Officer, County Counsel, the Director of Personnel and the Sheriff, Departments of Health Services, Mental Health, Public Health and Agricultural Commissioner/Weights and Measures named in the Motion.

We support a planning model that stresses the importance of meaningful mental health consumer involvement. The people served by the Department of Mental Health, both individually and through their client organizations, are very important stakeholders and must be involved in all planning processes. Within DMH the saying "Nothing About Us Without Us" is taken very seriously and those who receive services provide vital and necessary input to all planning. Transparency and inclusion are not only necessary but mandatory and must be demonstrated.

We support a planning model that focuses on the integration of services and the breaking of the siloes and barriers to integrated care. We feel this has been clearly demonstrated within DMH over the last three years in the Innovations I Projects (INN1).

We support a planning model that emphasizes the crucial importance of the Recovery Model. The work of DMH is very different from Health Services and Public Health. The Recovery Model which has been established and built over the past 10 years has allowed many people with a mental illness to learn about managing their illness and finding their potential with many supports along the way. Without a deep understanding of The Recovery Model and all that goes into supporting people, including special supports for our underserved populations, the work that has been done will be eroded.

We support a planning model that incorporates a unique feature of DMH in the development and inclusion of people with lived experience (peers) in the treatment teams. Peers are a unique part of outreach teams, in Wellness Centers, in treatment waiting rooms. This not only helps to break barriers with people who need treatment but it also builds the self-confidence and skills of the person with lived experience. Today we have many success stories of people who are leading peaceful, productive lives and have given back to others within the mental health community.

Part 5: Suggested Next Steps

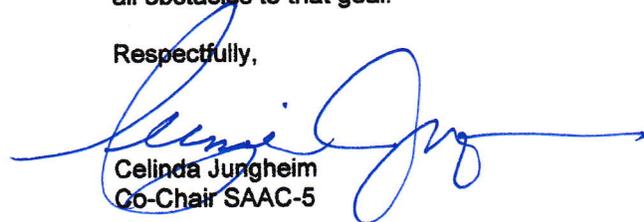
DMH has taken the lead in the County for several years to integrate services, and is currently poised to identify and begin to build health neighborhoods aligned with the integrated service model. DMH should be tasked to take the lead in any integration plans within LA County.

The creation of a planning council made up of at least representatives from each department, a deputy from each Supervisor's office, a representative from the CEO or CFO, agency representation, consumer representation and UREP representation. The decisions of the council would be open and transparent. Actions would include:

- Develop the short- and long-term priorities for better, more efficient integrated services in the county based on research, comparative studies and other resources.
- Identify the key county health needs and recommend how to address these.
- Determine what would be in the best interest of the consumer to receive better access and the highest quality of culturally competent and linguistically appropriate integrated care.
- Develop centralized data banks on resources among the three departments such as housing, outreach and engagement, reducing the homeless population, monitoring and supporting newly released prisoners to integrate back into their communities, employment services, public health information.
- Develop policies and procedures that would encourage teamwork and shared goals among the three departments in these areas.
- Monitor the workforce so that departments do not duplicate services.

Time does not have to be spent consolidating different departments. A better use of resources, including time, would be to focus on discussions that would result in better integrated services and the reduction of all obstacles to that goal.

Respectfully,



Celinda Jungheim
Co-Chair SAAC-5



Karen Macedonio
Co-Chair SAAC5

CC: Board of Supervisors
Mental Health Commission
Service Area Advisory Committee Co-Chairs