Mental Health Commission/Service Area 5 Town Hall
January 25, 2020, 9 am – 4 pm
Historical Women's Club in Santa Monica
Town Hall - Highlights

Welcome and Introductions – Commissioner Brittney Weissman, Mental Health Commission Chair
Roll Call

Present - Brittney Weissman, Kita Curry, Harold Turner, Stacy Dalgleish, Susan Friedman, Reba Stevens, Imelda Padilla-Frausto, Merilla Scott, Kathy Cooper Ledesma (Quorum) **Absent** – Patrick Ogawa-AE, Kevin Acebo-AE, Judy Cooperberg-AE, and Mike Molina-AE

Commissioners introduced themselves, spoke individually about personal experiences with mental illness, advocacies, and reasons for serving on the Commission.

Mental Health Commission Overview – Commissioner Friedman
Commissioner Friedman gave an overview on the role of the Commission and the process to approve MHSA annual report prior to board approval.

SA 5 Consumer Presentations and Activity

- Breath of Fresh Air – Trevion Beck and Adam Arce, Safe Place for Youth (SPY) both spoke on more funding for arts in youth programs and schools should be provided.

- Trevion Beck led the audience in a mindfulness exercise to reduce violent negativity and increase energy.

- "Community Street News" – Tristan Scremin, Painted Brain and Jim "The Hat" Whitener, SHARE! Chairs for the SA 5 client activity subcommittee, announced the new project, "Community Street News." A community newspaper featuring interviews highlighting people living on the streets, articles and resources to empower homeless people and others in crisis to rise above the situation."

- NAMI Westside – Tim Davis, President, gave overview of free education classes, support groups and more resources available for those impacted by mental health issues. Mr. Davis introduced Elizabeth Stephens who leads the SA 5 peer program. The peer program offers eight-week peer training classes and support groups.

SA 5 Programs and Resources Highlights – Jacqueline Wilcoxen, SA 5 Manager

Ms. Wilcoxen reported on programs and resources available in the service area.

- Two stakeholder processes collaborate to develop goals for the Westside Mental Health Network and SALT.

- Dr. Sherin spoke about several prevention initiatives that are available in the service area: three health neighborhood programs, child and family programs, outreach to Spanish speaking community (Promotores), and SPY.

- Treatment services are offered to children and families in schools, crisis services are available in ERs and community care centers.

- The Home Team serves disengaged, most serious, and persistently mentally ill population. The program is 100% field base and available 24/7.

Public Comments

SA 5 Town Hall

1. Speaker wants DMH to collaborate with the Arts Commission to work on art for mental health programs and help get arts dollars back into the schools.

2. More info and/or programs needed for families with children on in-home therapy, supervised play, and family therapy to help those create healthy functioning mental structure in their home.

3. Speaker shared her story on disability, a formally homeless advocate for rape victims, domestic violence victims, and children who were victims of rape.

4. Speaker spoke about being new to mental health and concerns about services.

5. The African-American community needs a group that focus only on their needs. AAA underserved puts African American "second" as always in American still "underserved".

6. Speaker stated the need for more temporary supported semi-independent housing programs. The program saved speakers life and helped remain independent. More of these programs needed countywide and make them co-ed.

7. Request for public to support local community gardens. Where there are no fences and free food growing it allows the community to heal. Library, hospitals, and much more are public resources that are mandatory. Community gardens like SPY are crucial to serving homeless and housing people. Nature is vital in urban settings for human beings. Turn vacant lots in each city into community gardens.

8. Speaker wants to see more funding for the arts for different service providers because the arts can be super transformative.

9. Speaker spoke about living in a shelter in SPA 5: Speaker felt traumas infantilized to the point where they opted to be street-based.

10. Speaker commented to give more attention to the elderly population to receive services to prevent homelessness, preventive medical care and elder abuse, and more screening for IPV in elderly adult couples.

11. Speaker advocated for strengthened programs and services for TAY. In Jan 19, entered the DMH Shelter at the LA LGBT center, lived there a month and saw a decline in mental health that led speaker back to the streets. Additionally, the inflexible bi-weekly meetings with DMH, forced speaker to choose between shelter and employment, despite the fact that employment is one of the goals of the program. This is a wake-up call to the fact that services are not one size fits all. For those with and background of trauma abuse, or incarceration, curfews, lack of transparency, and under-trained frontline staff make or break a clients' success in these programs. Therefore, speaker would like to advocate for more trauma-informed care, more individual-specific care, and more flexibility in these policies.

12. Spoke generally across services for insecure housing populations, not specifically at any agencies – lack of training for staff, both in the frontline, case management and staff indirectly working with housing insecure clients. Trauma informed care is important for anyone from security staff to accounting. People with agencies

are interconnected. Lack of self-care for both direct service and government staff incorporated into workplace leads to burnout decline in quality of services and overall turnover. Time is not made to have a conversation about this in the workplace. If we expect clients to find stability and balance living, staff need to set the example.

13. SMC serves students from multiple underserved groups and students need clinical services available on campus by clinicians who can provide intervention with a dreamer. DACA students as well as our students whose California Care insurance like Kaiser does not provide adequate psychiatric coverage.

14. What can we do about a facility in SAAC 5 that is treating members horribly? Speaker wants to help. Are there any laws?

15. SHARE! housed 532 mental health consumers in 2019 for less than $1 million. Twenty-six percent of those housed were homeless mental health consumers who got jobs and moved out to unsubsidized housing. The County cannot figure out how to fund SHARE! because housing money only comes in two categories 1) Capital of building, and 2) supportive services. They do not have any funding for single-family houses and setting them up as cultures of recovery. SHARE! if funded $3.5 million a year for 5 years could house 10 million mental health consumers. This is cheaper than shelter beds and the Americans with Disability Act means no NIMBY issues or costs. SHARE! houses 43% of mental health consumers within 2 days of their first contact with SHARE! Speaker invites the commission and anyone else to take a tour of some of the houses to see part of the solution to ending homelessness for mental health consumers in Los Angeles County.

16. Request – have more community events such as this one.

17. Possibly have adult daycare centers as a type of housing

18. Have more mental health first aid training for providers. Speaker has been trying to be certified for over a year and it has been difficult to get training.

19. Speaker commented around the need for more education and training around language usage, personal experience with Kaiser mental health the doctors are not fully compassionate.

20. So much of the preschool to prison pipeline happens even before preschool. Kids and parents living in households struggling with generations of harm need in-home therapy for whole families to end cycles of trauma. Protect the kids from future depression, addiction and homelessness.

21. Please provide an overview of prevention programs for seniors.

22. Comments made on Mental Health Student Services Act, health insurance act, SB 803, and Western Recovery Conference.

23. Are there ways to get support for small agencies with little funds and knowledge? As a small nonprofit providing creative arts therapy to survivors of violence and abuse, main challenge is being “the new kid on the block.” Speaker has found it difficult to navigate the various systems and funding as well as being known.

24. Speaker, clinician, (child therapist at DMH contract agency), wants to share that the “evidence based practices” particularly MAP, which are required to use with clients under PEI funding are a barrier rather than useful tool to

provide higher quality care. Per Dr. Sherin's comment, such requirements make clinicians accountable to the process but not the outcomes. Use of mandated "EBPs" devalues and hampers clinical judgement and expertise. It also creates copious amounts of required documentation (time which also costs $) which detract clinicians' focus on the therapeutic process. As a result, many sophisticated, skilled clinicians leave community settings because their work is undervalued and interrupted. Poor clients cannot access them then. It is also important to note that EBPs are generally based on research that screens out the co-occurring disorders and disabilities most of our clients have. It rarely reflects the acuity and diversity of our patient population. MAP also does not take into account the mental health (or lack thereof) of a child's parents, who are closely involved in treatment. Clinicians need to be free to meet clients where they are at and use clinical judgement to guide treatment rather than use ill-matched EBPs.

25. Speaker observed juvenile camps that had adequate well-trained and committed staff. They report success in education and training especially by the removal from "poisonous" environment with family and gang problems seems to benefit youth by removing them from "toxic" local environment–unless they go back!

Strategic Plan comments

1. How are self-help groups utilized? They are free (donations accepted) and offer support as well as help, which is adjunct to professional care. All agencies should require self-help groups led by peers who are given a stipend for their leadership.

2. Service Area 5 is in dire need of a drop-in center/shelter for young adults ages 18-28 experiencing homelessness. Daniel's Place has closed; a facility should be reopened out of the Santa Monica area. This population can be saved what is being done to help. Those who had a place to go are back on the streets in need of help.

3. Speaker spoke about having more ethical educational and empathy training to the ones making the decisions for those who have problems speaking for and about their situations. Proper alignment of care through distribution of people in need according to their own situations due to trauma and lack of communication skills.

4. How can we assist to move tent camps along city streets and under freeways?

5. Speaker shared that when their son became homeless he was able to qualify for and access to DMH services. Speaker reached out before he was homeless but nothing could be done. Middle class with insurance do not have all the services neither the benefits for a person with SSI. In the city of Santa Monica there are no walk-in services except ERs, the rest is history. SSI or no insured can walk to a Didi Hirsch and get services. UCLA mental health with the patient's doctor does not give any appointments when a patient is in a crisis. Speaker needed a professional to tell them how take care of the crisis at home without hospitalization.

6. Institutions/Reentry/LPS – Some individuals deemed so gravely disabled they continuously need conservatorships. They need residential treatment with psychosocial/psychiatric support on a long-term basis. Use John Henry Foundation as a model! These folk's needs are ignored.

7. $1.2 million grant for diversion pre-plea by public defender's office. Mental health responsibilities? Adequate inpatient services? Coordinated efforts with nonprofits. How is this different from 5150 or 5200 holds and pre-conservator process?

8. What is DMH doing to address LGBTQ12-S consumers financially? Is there funding specifically being directed to help these consumers on the ground? A solid plan or a policy to ensure these consumers feel the DMH is a safe place. Please pass the LGBTQ12-S mandatory training to cultural competency.

9. Speakers 27 year-old son was hospitalized 18 times, incarcerated once in less than 5 years before he was conserved. Every hospitalization, after the fifth visit, speaker pleaded with his inpatient doctors to conserve him, but to no avail. Can DMH create an LPS Conservatorship professional review panel to help caregivers create a case for conservatorship when inpatient doctors refuse to conserve?

Budget comment

1. Speaker is a child psychotherapist. At their clinic, they are told most of our funding is PEI. This requires them to use the EBP "MAP" for (most) clients age 6-18. These slides regarding PEI state -- for those "at risk of developing a mental illness or experiencing early symptoms and where short-term low intensity interventions" are appropriate. MAP may be appropriate for each short term low intensity needs. However, our outpatient population is much higher acuity than reflected in PEI or MAP definitions/indications. These funding streams/EBP issues become very cumbersome at the micro level for clinicians, and believe they result in inappropriate care for clients, particularly with newer clinicians who are less confident in straying based on their own clinical judgement, also witness how these issues contribute to more experienced clinicians leaving community settings for private practice even though they would prefer to serve a higher need population. In addition, we need to be able to bill for crisis intervention time/services when waiting for PMRT to come for a client even if the client is admitted to inpatient!