County of Los Angeles – Department of Mental Health

MENTAL HEALTH COMMISSION

SPECIAL MEETING

MHSA 3-YEAR PLAN PUBLIC COMMENT

Thursday, April 29, 2021

Brittney Weissman, Chair, Presiding

I. **Call to Order**

Roll Call – Imelda Padilla-Frausto (Here), Susan Friedman (Here) Harold Turner (Here), Reba Stevens (Here), Stacy Dalgleish (Here), Patrick Ogawa (Here), Kevin Acebo (Here), Michael Molina (Here), Brittney Weissman (Here), Judy Cooperberg (Here) **Absent**: Kathy Cooper Ledesma, Teresa Banko.

II. **MHSA Recommendation(s) Discussion**

Discussion concluded with a motion**. Commissioner Dalgleish motion to accept previously written perspectives and the addition of the data piece at the top of the recommendations. Second by Commissioner Padilla-Frausto** (see attached).

III. **Public Comments**

HECTOR RAMIREZ: Thanked Commissioners who spoke out for people of color. Made comments on agencies that continue to take advantage of communities only to advance their profit have limited understanding of the MHSA plan.

ESIQUIO REYES: Reemphasize the need for basic necessities of homeless individuals like food, etc., lack available and/or insufficient resources. Thank you very much.

OSBY SANGSTER: Asked that DMH commit funding and reestablish the housing trust fund and other support systems to assist homelessness because people have experienced over 140 years of chronic homelessness.

KATHLEEN AUSTRIA: Supports Reba's comments regarding criminal justice. The Oversight and Accountability Commission addresses jail services in the MHSA. The Second District is in full support and requesting that we take a closer look at criminal justice. Thank you.

IV. Adjourn

MHSA Recommendation(s) Discussion Points

Drafting Recommendation:
"Large Bucket" Focus Items & Sub-Items:
Board should review testimony that is rec'd from the stakeholders as the Board renders final recommendations on the 3 Year Plan

1. Disparities/Inequities
    a. DATA – improve data collection to identify inequities and identify data source that can be used to help with identifying unmet need / data sharing tools to allow to track how well recommendations are being implemented
    b. Cultural Competence
        i. Recs. from cultural comp ad hoc workgroup (Commissioner Ogawa)
        ii. Towards Language & Access to Info for families in multi-langs (PEI/Edu O&E)/13 thresholds
        iii. Towards Immigration Status
    c. Racial & Ethnic
    d. Geographic
    e. Perinatal
    f. Age – choice in program enrollment
    g. Condition
    h. Disparities among ADA Accessibility/Physical Disabilities
    i. Disparities in funding across underserved/unserved populations, including ethnic pops, SD2 and across all SDs
    j. Areas of Improvement
        i. Data Collection and Analysis
        ii. Enhanced tech driven tools and srvs
        iii. ID of sustainable funding
2. Tx/Services
    a. Psych Emerg. Srvcs / Therp. Srvcs
        i. Only 3 hospitals providing this level of srv, expansion nec. (consider 69+ hospitals in LAC)
        ii. Integrate the care
        iii. Contract considerations
    b. Access to Transport for adults SMI living in B&C, Inc. ability to access rec
    c. Therp. Srvcs
        i. Funding concerns re: IMDs, contracted srvs, Dept. request plans for therp. Srvs, budget line items before contracts are awarded
        ii. Inc. oversight and accountability for these services
    d. Home visitation
        i. Reconsider funding cuts
    e. Cultural arts programs as prevention
        i. Support and cont. to allocate funding and resources & culturally specific
3. Outreach to Families
    a. Improving education and resources when fam exp 1st mh crisis

i. Increase edu and resources to families
ii. Include w/ Mobile Crisis Response & immediately accessible – messaging
iii. Contract implementation – explicit outcome within provider contracts
iv. Adequate app. input from CBOs

b. Help with navigating systems of services
i. Support families in cul. supportive ways
ii. Warm hand offs between providers and other levels of care

c. Inclusion of families in the process of tx and srvs and care
i. "one size doesn't fit all" individualized
ii. Unique needs

4. Housing & Homelessness w/ MH
a. Prevention
b. Housing Retention
i. Education on prevention, resources or a place to go
ii. Ensuring those are connected in order to retain housing
1. Community bldg., community resilience / support SA communities / involvement in order to be informed

c. OVERSIGHT & ACCOUNTABILITY
d. Long term housing
i. Support connecting people to long term housing and with and around essential services

5. Criminal Justice
a. Mental Health & Substance Use/Abuse
i. ODR Reentry Program, inc. funding, must identify sustainable funds to support MH clients, leverage all sources of funding to vulnerable incarcerated individuals and others
ii. Leverage MHSA, matching $ - can they be leveraged?

b. Understanding the savings costs to county ($125/day per person incarcerated) / Implementing a true integrated system of care & leverage appropriate matching funds, review adequate savings of cost
c. Racial & Ethnic Inequities
i. Overrepresentation of Black people who are incarcerated, no place to go and the impact of that

d. Inc. Funding areas: Data collection, inc funding for sobering centers, inc funding for MET teams, diversion, LEAD, rec. based ct liaisons programs, juvenile adult collab cts , alt. sentencing options, inc. funding for beds, crisis teams
e. Acknowledge the report on the Black People Experiencing Homelessness Report as an added recommendation.

6. Impact of COVID-19
a. Impact on school-aged children
b. Impact on parents/families
i. Particularly on women, working women

c. Exacerbated racial and ethnic inequities and social economic inequities which lead to more MH issues among these pops and services need to be adequately tailored to these pops to meet their need.

Background

Per State law - Welfare Institutions Code (WIC) Section 5812.5(d), 5868(b), 5878.1(a); and 9 California Code of Regulations (CCR) Section 3200.100 — requires a county's' MHSA 3 Year Plan to address disparities, cultural and linguistic competency by incorporating and working to achieve the following goals listed below into all aspects of policymaking, program design, administration and service delivery. Each system and program is assessed for the strengths and weaknesses of its proficiency to achieve these goals. The infrastructure of a service, program or system is transformed, and new protocoled procedure are developed as necessary to achieve the following goals.

- Equal access to services of equal quality is provided, without disparities among racial/ethnic, cultural and linguistic populations or communities.
- Treatment interventions and outreach services effectively engage and retain individuals of diverse racial/ethnic, cultural, and linguistic populations.
- Disparities in services are identified and measured, strategies and programs area developed and implemented , and adjustments are made to existing programs to eliminate these disparities.
- An understanding of the diverse belief systems concerning mental illness, health, healing and wellness that exist among different racial/ethnic, cultural, and linguistic groups is incorporated into policy, program planning, and service delivery.
- An understanding of the impact historical bias, racism, and other forms of discrimination have upon each racial/ethnic, cultural, and linguistic population or community is incorporated into policy, program planning, and service delivery.
- An understanding of the impact bias, racism, and other forms of discrimination have on the mental health of each individual served is incorporated into service delivery.
- Services and supports utilize the strengths and forms of healing that are unique to an individual's racial/ethnic, cultural, and linguistic population or community they serve.
- Staff, contractors, and other individuals who deliver services are trained to understand and effectively address the needs and values of the particular racial/ethnic, cultural, and/or linguistic population or community they serve.
- Strategies are developed and implemented to promote equal opportunities for administrators, service providers, and others involved in service delivery who share the diverse racial/ethnic, cultural, and linguistic characteristics of individuals with serious mental illness/emotional disturbance in the community.

*T*he Board of Supervisors previously has addressed some of these areas such as:

** directing the DMH Director to develop strategies to reduce disparities in the delivery of mental health services to underrepresented ethnic and cultural communities, focusing on the Asian and Pacific Islander community, in part, how are these addressed in the DMH MHSA Three Year Plan. The motion also instructs DMH to report back to the Board of Supervisors on a gap analysis of disparities and areas that are underrepresented and how to address those issues throughout Los Angeles County. Subsequently, the Board passed other related motions in the areas of alternatives to incarceration, criminal justice and homelessness.

Data

The following provides a glaring picture of regarding unmet needs for mental health services among California and Los Angeles County Adults:

(A) In a recent UCLA Health Policy Brief, co-authored by Mental Health Commissioner Imelda Padilla-Frausto, "Based on data from the 2018 California Health Interview Survey (CHIS), approximately 11 million California adults were MHSA eligible due to their insurance status. Over one-quarter of these (3 million) reported psychological distress, with the majority (1.8 million) reporting unmet needs for services. Policies that could reduce this unmet need include expanding the breadth and reach of PEI programs and increasing efforts to develop a robust, culturally and linguistically competent workforce across all MHSA services."

Commission Padilla-Frausto also provided the MHC a supplemental document based on this policy brief that has LA County specific data:

"In 2018, over one-quarter or 700,000 of Los Angeles County MHSA-eligible adults reported symptoms indicating a need for public mental health services (Exhibit 1).

"• 15.1% or 500,000 MHSA-eligible adults reported symptoms associated with serious psychological distress, an estimate of adults with serious diagnosable mental health disorders that warrant mental health treatment.1

"• 12.0% or 400,000 MHSA-eligible adults reported symptoms associated with moderate psychological distress, an estimate of adults with mental distress that are clinically relevant and warrants mental health intervention. "

(B) The "LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH OFFICE OF ADMINISTRATIVE OPERATIONS - CULTURAL COMPETENCY UNIT - CULTURAL COMPETENCE PLAN UPDATE – FY 2019," pages 90-100, analyzes and assesses the unmet need for mental health services in the County, specifically:

**Disparity by Race/Ethnicity (African American, Asian/Pacific Islander Population, Latino, Native American, White) Within Service Areas 1-8.
**Disparity by Language.
**Disparity by Age (0-15, 16-25, 26-59, 60+) Within Service Areas 1-8; and,
**Disparity by Gender Within Service Provider Areas.

Data findings show those who have the great need for services include African American Latino and Asian American adults, adults who are noncitizen, and adults with no to low English proficiency, and pronounced in specific Service Areas of the County.

Recommendation

MHC urges the Board of Supervisors within its review of the DMH MHSA 3 Yr Plan and its budget to develop funding recommendations about these disparities, specifically or the Board of Supervisors' final review and approval of the Plan. MCH suggest hose areas where disparities exist:

1. Cultural and linguistic competency;
2. Utilization and penetration of DMH services by underrepresented communities;

3. Criminal Justice & Alternatives to Incarceration;
4. Homelessness; and,
5. Impact of the COVID pandemic.