

County of Los Angeles – Department of Mental Health
OFFICE OF THE MENTAL HEALTH COMMISSION

Thursday, March 27, 2014

~ **Approved Minutes** ~

Please note the minutes are a brief summary and not a word for word transcription of events at this meeting.

Larry Gasco, Chairman, Presiding

1. Call to Order – Larry Gasco

- The meeting was called to order by Larry Gasco
- Roll Call by Canetana Hurd
- Attendance recorded as follows:
Absent excused: Jerry Lubin, Herman DeBose, and Phillip Chen
- Update on Commissioner Jerry Lubin – Chairman Gasco spoke with Commissioner Lubin who is recovering nicely. Commissioner Perrou circulated a card to send Jerry a get well greeting.
- Agenda Switch – Chairman Gasco announced that the Public Comments section moved from Agenda Item No. 3 to No. 4 after the MHSA 3-Year Program and Expenditure Plan overview item due to time constraints.
- Approval of Minutes – Commissioner Sofro noted corrections regarding her report to be amended. Commissioner Perrou motioned for the approval of February 2014 minutes of the Commission.

Commissioner Baron seconded the motion to approve the amended minutes.

Chairman Gasco stated, the motion unanimously passes to approve the amended minutes with all members present and voting.

2. Chairman's Report – Larry Gasco

- Recognition – Chairman Gasco recognized the accomplishments of the following Commissioners
 1. Commissioner Judy Cooperberg – Received the honor of Los Angeles County Women's Commission "Woman of the Year" on March 10 representing the 5th District
 2. Commissioner Arnold Gilberg – Named "50-Distinguished Life Fellows and Life Members," the honor recognized Dr. Gilberg for 50 plus years of service to the psychiatric movement.
 3. Commissioner Herman DeBose – Presented at the international conference in Uganda on issues of poverty and tied together some of the elements of poverty in Los Angeles County and the State of California.
- **Retirement Celebration** – Chairman Gasco attended the retirement ceremony of Dr. Tony Beliz, along with Commissioner DeBose, Terry Lewis, and Susan Rajlal. The celebration was well attended by staff and law enforcement.

- **Executive Committee Report** – Chairman Gasco recapped action items from the February 24 meeting for follow up, particularly questions for Dr. Shea’s Jail Mental Health presentation and Cathy Warner regarding the wellness centers. Commissioners that have questions for Dr. Shea to help shape interest in jail mental health services submit them to Terry Lewis.

Chairman Gasco was invited by Patricia Russell to a meeting chaired by LA County District Attorney Jackie Lacey; Dr. Southard also attended. The meeting involved diverting people with mental illness who should not be incarcerated into community services. District Attorney Lacey stated the meeting is the first step of a series of complex meeting collaborations with many departments.

Chairman Gasco further reported he attended a conference on February 28 pertaining to the incarcerated population in LA County. Over 3 million are incarcerated. The Department of Justice appears to be insensitive to the numbers. He also reported on an article from Commissioner DeBose stating 80% of cocaine users are white but the majority of those arrested who will go to prison for cocaine related violations are black.

- **Annual Retreat Date** – The Commission determined Saturday, June 7, 2014 is the date for the annual retreat. The location is Descanso Gardens. Commissioner DeBose sent an email to Commissioners requesting feedback for the retreat agenda. Chairman Gasco asked Commissioners to please respond to Commissioner DeBose.
- **Status on Commission Vacancies** – Supervisor Molina will be making two appointments soon. Supervisor Knabe’s appointments are pending deliberations. Fourth District candidates are Angelo Oh and Sharon Lyle.
- **MHC/SAAC Chairs Report** – The meeting was held March 11. Terry Lewis reported service areas working on their plans. The SAAC Chair’s meeting promotes communication and partnerships. SAAC 1 and 2 collaborated on plans and recommendations to support the MHSA planning and program expansion. Angel Baker, Executive Manager, reported SAACs are interested in trainings unique to their service area. Ms. Baker announced that \$5,000 per SAAC is available from MHSA funding for training next fiscal year. Adrienne Hament, Training Coordinator, spoke on the Clergy Academy. A series of trainings are planned to look at coordination of mental health services for clergy to help clergy assist those in the community seek mental health services.

- **Legislative Report – Susan Rajlal reported:**

Ms. Rajlal announced two budget updates that relate to SB 82, notification that DMH received grant from OAC, and the CHFFA application needs some adjustments.

Ms. Rajlal further reported legislative issues. Half of the Los Angeles delegation in both the senate and assembly are new. Many do not know LA County issues until legislators are shown the demographics. Many are unaware of the number of people impacted by LA County. This year is

Senator Pro Tem Steinberg's last year, and mental health is in need of another champion. Ms. Rajlal met with representatives of Steve Fox office who requested stats from his area.

Ms. Rajlal spoke about attending the Capitol Action Day rally in Sacramento on May 13. Two topics will be the focus

- a) Disability Awareness Rally – Senator Steinberg is the honored guest and will do kick off.
- b) Continue with Capitol visits and invite the Commission to join the activities

Legislative Breakfast – MHSA funds are available for coordinating a Legislative Breakfast with legislators in specific service areas. Susan Rajlal indicated that this is a perfect time to meet and focus on issues because the new legislators know little about mental health and LA County, and money is available. November is an ideal month after elections to host the breakfast.

3. **MHSA 3 Year Program and Expenditure Plan Overview** **Debbie Innes-Gomberg, PhD.**

Dr. Innes-Gomberg handed out the plan overview (Attachment 1) and discussed the following components:

- Why we are doing the 3-year planning process and recommendations, to state its purpose and facts (page 1-4)
- Key Dates (information you need to know) (page 3)
- Board of Supervisor 3 priority program expansion and new programs (page 5-6)
 - a) Assisted outpatient treatment, court work, revolving program
 - b) IMD Step Down Program
 - c) CHFFA – building of residential facilities
- Program Expansion and New Programs for children, TAY, adults, and older adults (pages 6-14)

Children

- a) Family Wellness Centers (new) – welcome center where families and children in need of mental health services can go to obtain information and resources.
- b) Alternative Crisis Services (expansion) – SB 82 CHFFA grant— building of residential facilities
- c) Respite Care (new) supportive services intended to help relieve families from the stress and family strain from providing constant care for children with SED.

- d) Self Help Support Groups for Children (new) self-help support groups for four evidence-based self-help programs
- e) Promotores de Salud/Community Wellness Workers for children (new), train and stipend community workers who are trusted and have understanding of the community served.
- f) Field Capable Clinical Services (expansion) serve an additional 330 clients per fiscal year, including housing

TAY

- a) Promotores de Salud/Community Wellness Workers for TAY (new), train and stipend community workers who are trusted and have understanding of the community served.
- b) Self Help Support Groups for TAY (new), self-help support groups for four evidence-based self-help programs
- c) TAY Supportive Employment Services (new) provide supportive employment to TAY to increase self-sufficiency.
- d) Housing Trust Fund/MHSA Housing Program/FSP/FCCS/TAY Drop In Centers (expansion), additional funding, slots. 36 additional clients served, and 3 additional centers for TAY population

Adults

- a) Wellness Centers (expansion)-adjunct service and staffing expansion for adults
- b) Wellness/Client Run Centers (expansion) housing specialists per program to support clients with Section 8 vouchers maintain housing.
- c) Client Run Centers/FSP/FCCS (expansion) expand peer run center to cover every service area. Pilot "Life Coaches" program in Peer Run Centers, increase slots, and increase clients served.
- d) MHSA Housing Program and Housing Trust Fund (expansion) funding for affordable and permanent supportive housing, and expand current contracts which are ending for some agencies.
- e) Community Health Workers (new) add Promotores de Salud/Community Wellness Workers as a directly operated cross-cutting program across age groups in each service area.
- f) Co-occurring Disorders Services Training and Technical Assistance (new) provided through the UCLA Integrated Substance Abuse program

Older Adult

- g) FSP/FCCS/Housing Trust Fund (expansion) increase clients, and extend current housing contracts which are ending for some agencies.

Q & A regarding the MHSA presentation

- 1) Commissioner Sofro – what does CFTN mean

Answer – CFTN: Capital of facility and technological needs; 2 infrastructure components

- 2) Cary Grier-- Why is there no expansion for foster care with training?

Answer – Adult coordinators at SLT meetings highly supported co-occurring disorders involving UCLA trainings. FSP, FCCP services will be used to address the needs of TAY for expansion.

- 3) Patricia Russell –Will any other agencies be involved to train besides UCLA?

Answer – Maybe opportunities in WET partnerships because DMH is issuing a RFP for new partnerships for co-occurring disorders.

Dr. Innes-Gomberg concluded the plan shows clearly what funding can do to enhance and provide new programs. Feedback from SLT and 7 of 8 SAACs through presentations, ad hoc workgroups was valuable in a tight turnaround, and reflective of the community need.

4. **Public Comments**

Douglas George and Luda Olson, USC Public Policy Advocacy Class Interns participated in public comments as a class project – Attachment 2 (3 pages)

Jean Harris – Supports urgent care facility plan but after discharge where do the people go? There is lack of housing and other long term resources. Adult care homes opened and neighborhood expressed stigma and NIMBYSM (see articles Attachment 3).

William Legere – The need for more mental health clients in Master of Social Work Programs. Encouraged clients to go into MSW program because they have the experience.

Patricia Russell – I would like to recommend that DMH hire another Family Advocate. Helena Ditko is doing a good job but she herself tells family members that she needs more people. Calls are often not returned when there is an urgent need when a family member is in the hospital.

Dennis Miller – I want to let you know I am praying for you each day and advocating for others. I am the information man to God each day. My 69th birthday with my twin sister Joan Giles is on April 9 born the same year of our Lord in Glendale, California. I am 20 minutes older than my sister, God bless.

Barbara Wilson – Thanked Commissioner Cooperberg for coming to SAAC 2 to discuss law enforcement training. Regarding inter county coordination creating regional services to the Antelope Valley, I understand that SPA 1 needs to request that in writing. Please clarify; who to write to, to be submitted to whom; any copies to be distributed?

Gabriela Alhambra invited everyone to a Latino event on May 11.

5. **Commissioners' Reports**

Commissioner Delores Huffman Discussed the many comments on housing that occurred at the meeting. She further stated that she will announce to all the next housing meeting will take place.

Commissioner Victoria Sofro Connections for Life conference is Wednesday, April 2. Supervisors Mark Ridley-Thomas agreed to do opening remarks. Commissioners Perrou, Huffman, and Gasco plan to attend the conference.

6. **SAAC/Community Reports/LACCC**

This item is tabled due to the evacuation drill scheduled @ 2:30 and the detailed MHSA report.

7. **Meeting adjourned**

8. **NEXT MEETING**

Thursday, April 24, 2014
11 am - 1:30 pm
Kenneth Hahn Hall of Administration
Room 739
500 West Temple Street
Los Angeles, CA 90012

Minutes prepared by Canetana Hurd

Mental Health Services Act 3 Year Program and Expenditure Plan
Overview
Fiscal Years 2014-15 Through 2016-17



Purpose and Facts

- The Mental Health Services Act stipulates that counties shall prepare and submit a MHS Act Three-Year Program and Expenditure Plan
- The Plan must be adopted by the Board of Supervisors and approved by the Mental Health Commission
- The Plan requires a 30 day public comment period and a Public Hearing
- Mental Health Director and County Auditor Controller certification as to compliance with laws and regulations

Content of the MHSA 3 Year Plan

- Description of meaningful stakeholder involvement
- Documentation of public posting, public comments and public hearing, including any substantive changes made to the proposed plan
- Number of clients served and description of services
- Budget, including prudent reserve
- Cost per client for direct service programs
- Programmatic outcomes

Content of the MHSA 3 Year Plan

Community Services and Supports (CSS)
CSS Client Counts
CSS Programs
Full Service Partnership Outcomes
Alternative Crisis Services Outcomes
CSS Client Counts by Service Area
Prevention and Early Intervention (PEI)
PEI Client Counts
Evidence Based Practices Delivered
PEI Client Counts by Service Area
Early Intervention Projects and Implementation
PEI Practices Implemented
PEI Prevention Programs
PEI Outcomes
Training, Technical Assistance & Capacity Building
Workforce Education and Training (WET)
WET Regional Partnership
Technological Needs
Capital Facilities
Innovation
Budget

Key Dates

November 2013 – January 2014	Service Area Advisory Committee Orientation, Plan Review and Recommendations
November 2013 – February 2014	System Leadership Team synthesis of information and recommendation presented to the Department of Mental Health
March 19, 2014	Presentation of the plan to the System Leadership Team
March 27, 2014	Briefing of the Mental Health Commission
March 28, 2014	Public Posting of Plan for 30 days
May 23, 2014	Public Hearing convened by the Mental Health Commission
May 30, 2014	Attestations completed by the Auditor Controller and Director of Mental Health
June 2014	Board Letter presented at Agenda Review
July 2014	B - Board adoption and submission to Mental Health Services Oversight and Accountability Commission

Service Summary from FY 2012-13

- Unique clients receiving a direct Mental Health Service through the CSS Plan: **97,370**
- Unique clients receiving a direct Mental Health Service through the PEI Plan: **73,140**

Estimated LA County MHSA Budget

<u>FY</u>	<u>CSS*</u>	<u>PEI*</u>	<u>INN*</u>	<u>Total*</u>
2012-13	\$345	\$86.2	\$22.7	\$453.9
2013-14	\$271.2	\$67.8	\$17.8	\$356.8
2014-15	\$310	\$77.5	\$20.4	\$428.3
2015-16	\$304.4	\$76.1	\$20	\$400.5
2016-17	\$342.1	\$85.5	\$22.5	\$450.1

*Reported in millions of dollars

Total does not reflect current WET, CFTN or WET Regional Partnership funds.

Not inclusive of EPSDT, FFP or unspent funds from prior Fiscal Years

Fiscal Year budgets 2013-14 through 2016-17 are estimates based on projections by Mike Geiss, fiscal consultant for CMHDA

Allocation Plan for Unspent Community Services and Supports Plan Funds

- \$30 million/year for Fiscal Years 2014-15 through 2016-17
- Age group allocation agreed upon by the SLT:

Child	13%	Adult	61%
TAY	13%	Older Adult	13%

Program Expansion and New Programs By Fiscal Year- Board Priorities

Program Expansions:

Assisted Outpatient Treatment (AB 1421):

- Outreach and engagement (Service Area Navigation) These teams screen requests, conduct extensive outreach and engagement, develop petitions and manage the court processes to connect AOT enrollees with service providers primarily those who are Full Service Partnership Providers
- FSP (primarily adult) expansion
- Residential Services program will provide such services at selected Adult Residential Facilities.

\$3.8 mil. MHSAs for each FY to conduct approximately 500 evaluations per year, serve 300 clients, including about 60 crisis residential beds.

Program Expansion and New Programs By Fiscal Year- Board Priorities

Program Expansions:

IMD Step Down Program: Increase by 22 additional beds. IMD Step-Down Facilities are designed to provide supportive on-site mental health services at selected Adult Residential Facilities, and, in some instances, assisted living, congregate housing, or other independent living situations. The program accommodates persons being discharged from acute psychiatric inpatient units or intensive residential facilities, or those who are at risk of being placed in these higher levels of care who are appropriate for this service. The program targets those individuals in higher levels of care who require on-site mental health and supportive services to transition to stable community placement and prepare for more independent living.

\$1.2 mil. MHSAs for each FY

Program Expansion and New Programs By Fiscal Year- Board Priorities

Program Expansion:

Alternative Crisis Services: To accompany the SB 82 CHFFA grant (providing infrastructure), the following services will be expanded:

- Alternate Crisis Services provide a comprehensive range of services and supports for mentally ill individuals that are designed to provide alternatives to emergency room care, acute inpatient hospitalization and institutional care, reduce homelessness, and prevent incarceration.
- Urgent Care Centers (UCC) expansion to provide intensive crisis services to individuals who otherwise would be brought to emergency rooms. Harbor-UCLA Medical Center, South-East Los Angeles, the Antelope Valley and the San Gabriel area
- Crisis Residential Programs (IMD Step-down) to stabilize symptoms through medication intervention and develop social rehabilitation skills to facilitate community reintegration.
- serve 72 individuals at any given time and 35 new Crisis Residential Programs to increase capacity by 560 beds countywide.
- \$ 3mil. MHSA each FY

Program Expansion and New Programs By Fiscal Year - Child

New Programs

Family Wellness Centers: Family Wellness/Resource Centers (FWRC) are designed to act as a welcoming and family-friendly center within the community where families with children in need of mental health services can go to obtain information and resources to navigate the mental health, physical health and educational systems and participate in self-help meetings and workshops. FWRCs include a resource library and computer stations for families within the community and offers peer counseling, parent support groups and educational classes. FWRCs are located within established community organizations.

FY 15/16: \$750,000 FY 16/17: \$750,000

Program Expansion and New Programs By Fiscal Year - Child

New Program:

Respite Care Services: Positive, supportive services intended to help relieve families from the stress and family strain that result from providing constant care for a child with Severe Emotional Disturbance (SED), while at the same time addressing minor behavior issues, implementing existing behavioral support plans, and assisting with daily living needs.

FY 15/16: \$500,000

FY 16/17: \$500,000

Estimated clients to be served/Fiscal Year: 166

Program Expansion and New Programs By Fiscal Year - Child

New Program:

Self-Help Support Groups for Children: Self-help support groups for four evidence-based self-help programs: 1) Rainbows for children (4-15) who have experienced trauma, death, divorce, violence, removal from home and other losses; 2) La Leche League for at risk children 0-5 to establish healthy parental attachment; 3) Alateen for children (13-15) who have parents with mental health, substance abuse or other dysfunction in their families; 4) Because I Love You for parents of Children(10-15) with ADD, mental health and other behavioral issues.

FY 15/16: \$75,000 FY 16/17: \$75,000

Program Expansion and New Programs By Fiscal Year - Child

New Program:

Promotores de Salud/Community Wellness

Workers: *Promotores de Salud/Community Health Workers* are trained and stipended community members who are trusted members of and/or have an unusually close understanding of the community served. Promotores de Salud / Community Health Workers (CHWs) generally share the ethnicity, language, socioeconomic status, and life experiences of the community members they serve.

FY 2014/15: \$ FY 15/16: \$250,000 FY 16/17: \$250,000

Program Expansion and New Programs By Fiscal Year - Child

Program Expansions:

Field Capable Clinical Services: to serve an additional 330 clients per FY (\$1.13 mil for 14/15, 15/16, 16/17)

Housing Trust Fund: \$250,000 for FY's 15/16 and 16/17

MHSA Housing Program: \$200,000 for FY's 15/16 and 16/17 to build permanent housing.

Program Expansion and New Programs By Fiscal Year- TAY

New Program:

Promotores de Salud/Community Wellness

Workers: Trained and stipended community members who are trusted members of and/or have an unusually close understanding of the community served. Promotores de Salud / Community Health Workers (CHWs) generally share the ethnicity, language, socioeconomic status, and life experiences of the community members they serve

FY 14/15: \$228,000 FY 15/16: \$228,000 FY 16/17: \$228,697

Program Expansion and New Programs By Fiscal Year- TAY

New Program:

Self-Help Support Groups for TAY: Using four evidence-based self-help programs:1) Rainbows for TAY (15-18) who have experienced trauma, death, divorce, violence, removal from home and other losses; 2) La Leche League for pregnant TAY support for attachment parenting and breastfeeding; 3) Alateen for teens who have parents with mental health, substance abuse or other dysfunction in their families; 4) Because I Love You for parents of TAY (15-30) with ADD, mental health and other behavioral issues.

FY 15/16: \$45,000 FY 16/17: \$45,000

Program Expansion and New Programs By Fiscal Year- TAY

New Program:

TAY Supportive Employment Services: Provide supportive employment services to TAY (ages 18-25) to increase their self-sufficiency by obtaining and maintaining gainful employment maintaining stable housing. 75% of the TAY enrolled in the program will achieve employment success, as defined by maintaining their employment for a period of 6 months. 90% of the TAY enrolled in the program will maintain their housing situation.

FY 14/15: \$125,000 FY 15/16: 500,000 FY 16/17: \$500,000

Estimated clients: 30 125 125

Co-Occurring Disorders Service Training and Technical Assistance- FY 15/16: \$36,391 FY 16/17: \$36,391

Program Expansion and New Programs By Fiscal Year- TAY

Program Expansions:

Housing Trust Fund: FY 14/15: \$46,950, FY 15/16: \$610,000, FY 16/17: \$610,000

MHSA Housing Program: \$550,000 for FY's 14/15, 15/16 and 16/17

FSP: 18 additional slots (\$141,000 for each FY)

FCCS: 36 additional clients served, (\$88,000 for each FY)

TAY Drop In Centers: 3 additional centers. FY 14/15- Serve additional 400 clients with \$250,000. FY 15/16 and 16/17, serve an additional 1,200 clients with \$750,000

Program Expansion and New Programs By Fiscal Year- Adult

Expansion Programs:

Client-Run Centers: Expand Peer Run Centers to ensure availability in every service area. Increase support to pilot "Life Coaches" in Peer Run Centers. Expand Peer Run Center staff to ensure services are available in multiple languages and meet cultural needs.

FY 14/15: \$250,000 FY 15/16: \$1 mil. FY 16/17: \$1 mil.

Additional clients: 500 2,000 2,000

FSP: FY 14/15 – increase slots by 25, FY 15/16 and 16/17, increase slots by 100.

Additional slots to be added for successful Innovation models/agencies providing integrated care at the conclusion of INN Projects (\$750,000)

Expand psychiatric capacity (4) \$350,000 for each of FY's 15/16 and 16/17

FCCS: FY 14/15 increase clients by 50, FY 15/16 and 16/17 increase clients by 200.

Additional capacity to fund successful Innovation models/agencies providing integrated care at the conclusion of INN Projects (\$250,000)

Program Expansion and New Programs By Fiscal Year- Adult

Expansion Programs:

MHSA Housing Program: An investment in capital development and operating subsidies to expand the number of affordable, permanent supportive housing units for DMH clients. Funding goes through CalFHA.

FY 14/15: \$2.5 mil.

Housing Trust Fund: Extending the current 5 year contracts which are ending for some agencies. The funding will also allow us to expand supportive services to more permanent supportive housing programs.

FY 14/15: \$156,500 FY 15/16: \$980,000 FY 16/17: \$1.6 mil.

Program Expansion and New Programs By Fiscal Year- Adult

New Programs:

Community Health Workers (Promotores): add *Promotores de Salud* /Community Health Workers as a directly operated, cross-cutting program across age groups, within each Service Area. *Promotores de Salud*/Community Health Workers are trained and stipended community members who are trusted members of and/or have an unusually close understanding of the community served. Promotores de Salud / Community Health Workers (CHWs) generally share the ethnicity, language, socioeconomic status, and life experiences of the community members they serve.

FY 14/15: \$350,000 FY 15/16: \$350,000 FY 16/17: \$350,000

Program Expansion and New Programs By Fiscal Year- Adult

New Programs:

Co-Occurring Disorders Services Training and Technical Assistance: Provided through the UCLA Integrated Substance Abuse Program.

FY 15/16: \$170,000 FY 16/17: \$170,000

Program Expansion and New Programs By Fiscal Year- Older Adult

Program Expansion:

FSP: Increase by 109 clients. \$930,296 per FY

FCCS: Increase by 407 clients. \$1.4 mil per FY

Housing Trust Fund: Extending the current 5 year contracts which are ending for some agencies. The funding will also allow us to expand supportive services to more permanent supportive housing programs. \$250,000 per FY.

PRINT YOUR NAME AND COMMENTS CLEARLY TO ASSURE YOUR INFORMATION IS INCLUDED IN THE MINUTES ACCURATELY.

1

Los Angeles County Mental Health Commission
P U B L I C C O M M E N T F O R M
 (Request to address the Commission)

NOTE: Complete form, return to commission staff. Comments from the public on items of public interest within the Commission's subject matter jurisdiction, please limit comments to **THREE (3) minutes** unless the time is adjusted by the Chair.

DATE: March 27, 2014

NAME: Douglas George and Luda Olson

COMMENT: (If you need additional space, use the reverse side)

We are here today advocating for S.162/H.R. 401, the Justice and Mental Health Collaboration Act of 2013 (JMCA). This bipartisan bill is vitally important to the criminal justice and mental health fields.

Individuals with mental health conditions are significantly overrepresented in the criminal justice system. In a recent five-site study of people in U.S. jails, 14.5% of men and 31% of women had a serious mental illness – rates in excess of three to six times those found in general populations. Taken together, these numbers comprise 16.9% of the jail population.

In 2004, Congress passed the Mentally Ill Offender Treatment and Crime Reduction Act, which supports collaborative programs that address the needs of justice-involved individuals with mental health conditions. This Act enhances public safety by funding training for law enforcement officers on how to identify and respond to incidents involving people with mental illnesses, increasing mental health courts nationwide, improving collaboration between criminal justice and mental health systems, and improving access to effective treatment.

The JMCA reauthorizes and improves this critically important program. In addition to extending the act for five years, the bill provides additional resources for veteran treatment courts, increases focus on resources and training for jails and prisons, and provides innovative training at police academies. This important legislation will ensure that state and local governments can continue to design and implement sound initiatives that improve the criminal justice system, increase public safety, reduce state and local spending, and help individuals with mental illnesses.

PRINT YOUR NAME AND COMMENTS CLEARLY TO ASSURE YOUR INFORMATION IS INCLUDED IN THE MINUTES ACCURATELY.

2

Los Angeles County Mental Health Commission
PUBLIC COMMENT FORM
(Request to address the Commission)

NOTE: Complete form, return to commission staff. Comments from the public on items of public interest within the Commission's subject matter jurisdiction, please limit comments to **THREE (3) minutes** unless the time is adjusted by the Chair.

DATE: March 27, 2014

NAME: Luda Olson

COMMENT: (If you need additional space, use the reverse side)

I am here today advocating for the Justice and Mental Health Collaboration Act of 2013 (JMCA). The jails in United States are rapidly filling with inmates who have mental health illnesses, an issue which endures as a societal problem of significant scope. There are over three times more seriously mentally ill individuals in jails than in mental hospitals across the country, making this a national problem. The decrease of mental health services available to the mentally ill population contributes significantly to the increase of reoccurring incarceration of mentally ill individuals.

Due to the lack of medication and mental health services it presents a health and safety problem for all the communities with mentally ill individuals. Just yesterday, I was in a meeting at senior center that I volunteer at and they were strategizing how to stay safe from a homeless mentally ill individual who has been frequently coming. Unfortunately, they serve seniors, so they have to refuse services to him. Although, they have made referrals, but due to his illness he did not follow through. The staff at the senior center are afraid that he will become violent and they will need to call 911.

In this situation, the police will most likely come and take him to jail if he refuses to leave. There is no room in our Los Angeles county jails. About 90 percent of mentally ill inmates in the Los Angeles County Jail are repeat offenders, with 31 percent previously being incarcerated ten or more times. This is a huge number, we are spending more money on the repeat mentally ill inmates than they would on the prevention and treatment. It costs the government more money to house an inmate with mental health illness compared to providing treatment and services to the mentally ill individual.

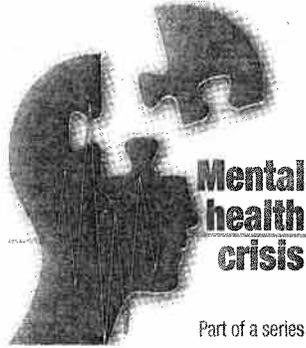
There has been numerous studies reviewing the effectiveness of the mental health courts with assertive community treatment programs resulting in positive improvement

PRINT YOUR NAME AND COMMENTS CLEARLY TO ASSURE YOUR INFORMATION IS INCLUDED IN THE MINUTES ACCURATELY.

in alcohol abuse, fewer days in jail, fewer arrests than before, and the rate of re-arrest was slower. These programs do work, it is important for the Justice and Mental Health Collaboration Act S. 162/ H.R. 401 to pass in order to continue to providing services to the mentally ill individuals.

This bill would ease the significant societal problem of mentally ill individuals reoccurring in the criminal justice system. It would reduce the cost of spending of housing mentally ill individuals in jails and instead provide mental health services, including treatment plans. And most importantly, these mentally ill individuals may have an opportunity to become productive citizens in our communities instead of being a safety threat.

AV lacks mental health care



Region's numbers at bottom of county

By **ANDREW CLARK**
Valley Press Staff Writer

EDITOR'S NOTE: First of a three-part series on mental health services in the Antelope Valley.

LANCASTER — A homeless man would spend his nights outside a local Wal-Mart in temperatures as low as 30 degrees and take items from the store under the delusional notion that he owned the store.

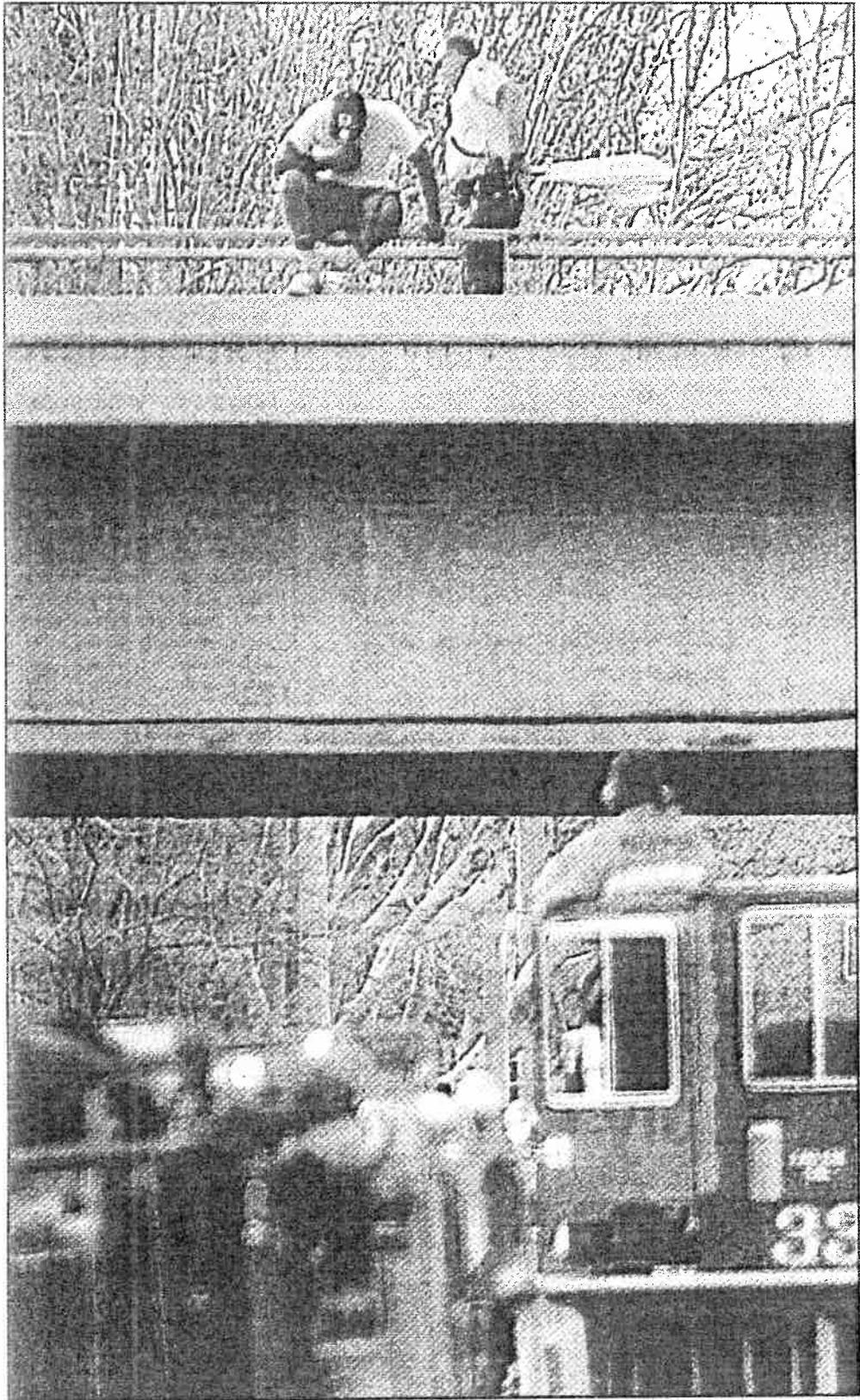
So said Laurie Ross, a clinical social worker at Antelope Valley Hospital's mental health unit with 30 years' experience.

"When he was arrested by police, he didn't know why," she said. "He thought it was his stuff."

On one occasion, according to Ross, she tried to reason with him, but he did not know she was there. Such is the toll imposed on people who suffer schizophrenia, a mental illness often characterized by hallucinations and voices. Its victims periodically lack attachment to reality.

In a similar, unrelated case, another man with schizophrenia developed the ability to recognize when he psychotic episodes were coming on. This man had a stable job and a support system around him. Nevertheless, about two years ago, according to Ross, "he walked in front of a train."

See CARE on A8



Valley Press files

ON THE EDGE — A man considers jumping off the northbound Antelope Valley Freeway onto Lancaster Boulevard in 2012.

CARE

From A1

And as depicted by Valley Press photographers, some so stricken by suicidal impulse will consider a plunge into the Antelope Valley Freeway unless seized by rescuers.

These are just a few of hundreds of cases highlighting the plight of those who suffer mental illness in the Antelope Valley and their inability to get necessary services.

Judy Cooperberg, director of the Antelope Valley Enrichment Services office of Mental Health America, stressed the gravity of the problem.

"We have the highest rate of suicide and depression in the country and the least amount of services available," Cooperberg said.

According to the 2013 Los Angeles County Key Indicators of Health report, the Antelope Valley trended dangerously in several categories.

The suicide rate of 8.6% is second only to West Los Angeles and is higher than the country average. However, county officials stress that all rates within Los Angeles County are less than the national average of 12.1%, and the data may have been calculated based upon a standard of number of deaths by suicide per 100,000, which may create an artificially high suicide rate with smaller populations.

In the case of the Antelope Valley service area of Los Angeles County, the population is approximately 387,000.

The rate for those who are in an ongoing struggle with depression is 12.6%, the highest in the county.

The rate of the population that has ever been diagnosed with depression is 14.6%, also the highest in the county. The depression risk rate is 11.9%, the third-highest rate in the county.

In the same report, the rate of the population that has ever been diagnosed with anxiety is 15.9% per 100,000, the highest in the county.

Also in the study, the percentage of children ages 3 to 17 who tried to get behavioral or mental health care in the past year was 11.4%, the highest in the county.

Adults fared a little better with an 8.3% rate, the fourth-highest in Los Angeles County.

On a national level, Dr. Robin Kay, Chief Deputy Director for Los Angeles County Department of Mental Health, said the number of residents battling mental health issues is higher than people realize.

"One in five people will have a diagnosable mental health challenge," she said.

She was quick to add a mental health challenge could range from mild anxiety or a case of mild depression to more severe disorders such as schizophrenia.

When California voters passed Proposition 63 in 2004, the measure was signed into law a year later as

the Mental Health Services Act, or MHSA.

Prop. 63 was intended to expand and transform California's county mental health service systems. The act is funded by imposing an additional 1% tax on individual, but not corporate, taxable income in excess of \$1 million.

As part of that measure, every county has plans for local services offered, including a Community Services and Supports Plan. The plan's goal is to provide an array of around-the-clock services to all age groups whose needs are not met through other funding sources.

Mental health is funded in part by full-service partnership allocation slots, a key component of the Mental Health Services Act. Each county divides its allocation slots based on a variety of factors, such as poverty and level of need.

"First we identify the money, then we determine how many services that additional money will buy," Kay said.

According to county mental health department officials, the allocation slot numbers were established in the mid-2000s, but officials are reassessing the data.

In the interim, though, directors of local agencies are trying to cope with a lack of support.

"The past two years, the counties have struggled," said Jean Harris, the director of the Antelope Valley chapter of the National Alliance



Part of a series

on Mental Illness. "Funding was dropped at a county level. It's a lot of work to regroup."

Cooperberg said slots are allotted to an agency, such as Mental Health America, and each agency is paid at a set rate per client served.

As a result, Cooperberg said Mental Health America's contract with the Department of Mental Health limits the number of clients they can serve. Therefore, the more slots an area has, the more agencies can serve a greater number of clients.

During the 2012-13 fiscal year, there were only 90 allocation slots available for adults, with the Valley

ranked last in the county.

By comparison, the top slot allocation district was South Bay with 850 Transitional-age youth, or those in their late teens and early 20s, only had 43 slots in the Antelope Valley, whereas the South Bay again took the top spot with 239 Children in the Valley had 50 slots available, whereas South Los Angeles had the most with 362. Antelope Valley seniors had 18 slots, but the top region, which covers the San Fernando and Santa Clarita valleys, had 72.

Cooperberg was appointed 2½ years ago to a commission on mental health for Los Angeles County. She is the first person from the Antelope Valley to be on the board in 60 years.

At a community hearing in December, scores of Antelope Valley residents and mental health professionals gathered at the Mental Health America office in Lancaster to meet with the commission and discuss the problems involving the lack of funding.

Harris said it was a turning point.

"We started getting heard. I'll never forget one of the commission-

ers saying, 'I thought she (Cooperberg) was just exaggerating.'"

Los Angeles County Supervisor Michael D. Antonovich has made mental health funding a priority, his communications director Tony Bell said. The 5th Supervisorial District includes the Antelope Valley.

"We are asking the department to address shortfalls," Bell said. "The Antelope Valley cannot be shortchanged in terms of service." Bell added that the funding needs to be equitable for all of Los Angeles County.

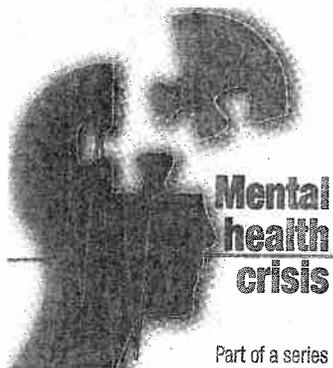
County officials realize there will have to be changes.

"I am working with the department director of transition-age youth to specifically address capacity issues in the Antelope Valley," Kay said. "We're trying to realign services."

As county officials work to reorganize services, local agencies such as Antelope Valley Hospital and the sheriff's stations in Palmdale and Lancaster are part of a group trying to address the unmet needs of Antelope Valley residents suffering from mental illness.

article@apnews.com

System 'overwhelmed'



**Mental
health
crisis**

Part of a series

AV mental health officials seek funds

By **ANDREW CLARK**
Valley Press Staff Writer

EDITOR'S NOTE: Second of a three-part series on mental health services in the Antelope Valley.

While county health officials struggle to realign services across the region, local agencies are working to address the severity of the problem as best they can.

"We don't have any treatment options available," said Jean Harris, the director of the Antelope Valley chapter of the National Alliance on Mental Illness. "The system is overwhelmed."

Judy Cooperberg, director of the Antelope Valley Enrichment Services office of Mental Health America, sought officials to address five unmet needs in the Antelope Valley as well as get increased funding.

The first involves the creation of a Mental Health Evaluation Team, or MET, a joint effort between mental health experts and law enforcement.



Valley Press files

LIVING QUARTERS — Sheriff's Deputy Mike Rust checks a tent at a homeless encampment in central Lancaster. Valley law enforcement officials report a significant number of homeless people have mental health problems. Workers in the mental health field say that the Valley system is overwhelmed.

The idea is for law enforcement to act as peace officers, talking volatile situations down instead of increasing tensions and possibly contributing to tragedy, like the death of a homeless man at the hands of police officers in Fullerton.

Education of law enforcement and mental health workers, and an ability to work together, is key to the effort.

Psychiatric Mobile Response Team services are limited in the Antelope Valley and cannot cover

all the geographic area or service needs.

PMRT in the Antelope Valley prioritize calls for youth, leaving adults needing crisis intervention solely to the over-burdened Sheriff's Department.

Capt. Don Ford, commander of the Palmdale Sheriff's Station, said deputies detain a large number of the mentally ill each year.

"At least half of the people we arrest have some form of mental illness or disability," he said.

Ford said the cases run the gamut from Attention Deficit Hyperactivity Disorder to depression to schizophrenia, the latter two of which are severe mental illnesses that can lead to loss of touch with reality or suicide.

Last year, the Palmdale station detained 389 people for a 72-hour hold at a local hospital, usually Antelope Valley Hospital or Olive View-UCLA Medical Center in Sylmar. Also last year,

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SYSTEM: Official should hear about funding 'within 2 months'

From A1

there were 72 cases of suicide or suicide attempts handled by Palmdale Sheriff's Station.

Cooperberg said a large number of calls into the Sheriff's Department regarding mental illness take place within the region.

"Over 40% of mental health calls for sheriff's deputies are in the Antelope Valley," she said, citing numbers Ford presented at a commission hearing in December.

For the Lancaster station, the numbers are not any better. Deputies detained 416 people for a 72-hour hold at a hospital and there were 87 cases of suicide or suicide attempts.

According to the Los Angeles County Sheriff's Department, "Of the nearly 20,000 inmates housed daily within the Los Angeles County jails, approximately 2,000 are diagnosed with a mental illness, 90% of which report co-occurring substance abuse."

"We run one of the largest mental health hospitals in the country," Ford said, expressing that the county jails unfortunately function as a collection point for the severely mentally ill who come into encounter with law enforcement.

In an effort to offset the lack of a MET team in the region, about 20 law enforcement officials, military personnel and security guards gathered earlier this month at the Lancaster offices of Mental Health America Enrichment Services of the Antelope Valley to receive training in handling mentally ill people.

Sgt. Don Hudalla, a 31-year veteran of the Los Angeles County Sheriff's Department and training officer for the program, said mental illness can affect anyone.

"Mental illness crosses all social and economic lines," he said. "Mental illness is a spectrum. It's a scale."

The second unmet need is a psychiatric urgent care for both adults and children. The only mental health hospital unit in the region is a 12-bed facility for adults at Antelope Valley Hospital. Children and patients that cannot get into the unit often have to travel to Olive View.

Harris relayed multiple stories of patients waiting as much as three days in the emergency room for psychiatric care.

However, Harris also sees a solution in the near future.

"We have plans in process to provide for a psychiatric urgent care within two years," she said.

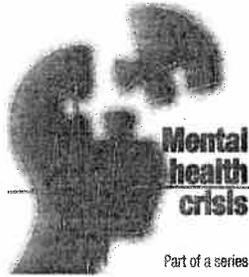
According to Harris, Antelope Valley Hospital will be the likely home for the urgent care.

"I believe the hospital has provided the space," she said.

Dr. Robin Kay, chief deputy director for Los Angeles County Department of Mental Health, said SB 82, the Investment in Mental Health Wellness Act of 2013, which was signed into law last June, should cover costs of building such a center.

"We should hear about the funding within two months," she said.

Kay added that the county has plans for four psychiatric urgent care centers and that "the AV is at the top of the list." County officials look to provide up to 23 hours of crisis intervention, case manage-



ment and other care services at the urgent care upon opening.

Capacity issues are a third unmet need that has yet to be addressed. According to Cooperberg, "The community supports increasing overall funding capacity for all age groups at all levels of care — with attention to the most vulnerable and highest risk residents."

Cooperberg used the Antelope Valley's foster youth as an example where the population vastly outnumbers support staff.

A fourth unmet need involves a conglomeration of homeless services, housing and transportation needs. According to Cooperberg, residents suffering from mental illness have had difficulty passing background and credit checks required to rent housing while landlords are uneasy about renting to people with mental disorders, citing previous experiences. In addition, Mental Health America clients and other people suffering from mental illness have shown fear, confusion and, ultimately, frustration about taking public transportation.

The homeless problem extends into local hospital facilities.

"We get a lot of people who are homeless that come to the hospital," said Laurie Ross, a clinical social worker at Antelope Valley Hospital's mental health unit. "When they come into the unit, they'll say, 'Three hots and a cot.' At any given time, we have several patients who are homeless."

Another unmet need involves the difficulty to bring psychiatrists to the region, which then causes a trickle-down effect. Because of a dearth of psychiatrists, patients have long wait times to see a doctor and some agencies, particularly the Department of Mental Health, defer to telemedicine.

Staff members from Mental Health America, National Alliance on Mental Illness, and Antelope Valley Hospital agreed on the lack of psychiatrists, but Cooperberg flatly spelled out the issue.

"We have a great difficulty recruiting and retaining psychiatrists in this valley," she said.

Harris said there have been cases of psychiatrists that start to drive up from Los Angeles, only to then turn around and turn down the job, citing the long commute or lack of area amenities.

"There is an apparent stigma associated with the desert," Harris said. "It is something we have to overcome."

She added that she was not a fan of the practice of telemedicine, where patients use videoconferencing tools to talk to doctors at Olive View or another facility.

"I personally find visiting a



Contributed

TOUGH SITUATION — Mental illness can affect anyone, said Sgt. Don Hudalla, a 31-year veteran of the Los Angeles County Sheriff's Department. Hudalla helped train about 20 law enforcement officials, military personnel and security guards earlier this month at the Lancaster offices of Mental Health America Enrichment Services of the Antelope Valley in handling mentally ill people.

What is a MET Team?
MET stands for Mental Health Evaluation Team and is a joint effort between law enforcement and mental health professionals to service calls in the community that involve the mentally ill. Currently, there is no MET team in the Antelope Valley. According to Cooperberg, the Department of Mental Health has identified funding for it and both Capt. Don Ford and Capt. Pat Nelson have voiced support for a team, but the Los Angeles County Sheriff's Department has not had the funding.

What is a PMRT?
A PMRT, or a Psychiatric Mobile Response Team, is a team of licensed clinical staff from the Department of Mental Health. According to DMH, Teams have legal authority to initiate applications for evaluation of involuntary detention of individuals determined to be at risk of harming themselves or others or who are unable to provide food, clothing, or shelter as a result of a mental disorder. Currently, a PMRT team does work in the Antelope Valley, but they prioritize calls involving children, leaving adult crises to sheriff's deputies.

psychiatrist via videophone unacceptable," Harris said.

One of the Valley health facilities that has shouldered the burden of issues pertaining to mental health is Antelope Valley Hospital, home to the region's only mental health unit. The alternative is a long trek to Olive View.

Dr. Roger Girion, a clinical psychologist at the hospital, said the 12-bed facility is not enough to meet the demand.

"The population easily supports a 30-bed facility," he said.

The unit is licensed for 30 beds, Dr. Girion added.

Laurie Ross, a clinical social worker at the hospital's mental health unit, suggested a shortage of staff is the primary culprit for not being able to offer a 30-bed facility.

"We can't go back up to the amount of beds we used to have, because we don't have enough doc-

tors to support it," she said.

Dr. Girion also said financial wrangling between state programs and doctors have done no favors for patients.

"The hospital has been shafted on payments from Medicare and Medi-Cal," he said. "A lot of doctors won't take Medicare and Medi-Cal."

Dr. Girion said it has gotten better, but previously, Medicare and Medi-Cal often denied payments, saying the patients were just looking for a place to stay overnight. He also said the unit actively tries to send patients to local support programs.

"We refer a lot of people to Mental Health America and those programs, but they don't have adequate funding," the doctor said.

"It's a damn crime," Dr. Girion added when asked about the lack of funding. "It's a failure of our society."

Ross explained her role in the mental health unit.

"I lead patients and work with them in groups, one-on-one, or help them with team meetings and discharge plans," she said.

"We'll always try to get them the services they need," she added.

According to the 2013 Los Angeles County Key Indicators of

“There is an
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— Jean Harris, Antelope Valley
chapter director, National Alliance
on Mental Illness

Health report, the Antelope Valley trended dangerously in several categories.

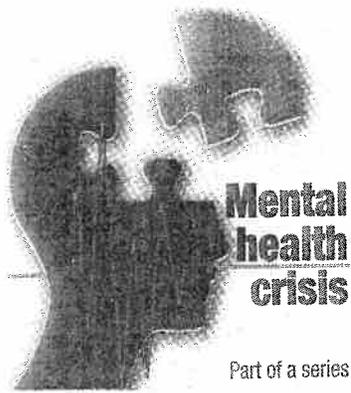
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In the case of the Antelope Valley service area of Los Angeles County, the population is approximately 387,000.

The current rate for those who are in an ongoing struggle with depression is 12.6%, the highest in the county. The rate of the population that has ever been diagnosed with depression is 14.6%, also the highest in the county. The depression risk rate is 11.9%, the third-highest rate in the county.

In the same report, the rate of the population that has ever been diagnosed with anxiety is 15.9% per 100,000, the highest in the county.

Services that are hard to come by, especially with a mental illness such as schizophrenia, or an array of mental health challenges faced by many Valley residents.



Mental illness takes big toll

By **ANDREW CLARK**
Valley Press Staff Writer

EDITOR'S NOTE: Last of a three-part series on mental health services in the Antelope Valley.

As local agencies work to address the needs of the mental health population in the Antelope Valley, certain illnesses are taking their toll.

Also, the aftereffects of the Great Recession, the implosion of the Valley's housing market, have added their stamp on the area's mental health map, imposing economic impacts as well as human misery.

For example, a veteran of the Vietnam War diagnosed with Post Traumatic Stress Disorder loses a good job in aerospace because of federal budget cutbacks. This triggers loss of income and loss of the family home, with family shifted to relatives or living in vehicles. Result? Severe depression.

Or, a professional with a good income must retire or resign from the principal income job in order to safeguard a grown son, or daughter, who is manifesting signs of mental illness — becoming a dan-

See **ILLNESS** on A5

ILLNESS

From A1

ger to themselves and others.

The professional's career is over, or deferred indefinitely.

The most common diagnosis rendered at Antelope Valley Hospital's mental health unit is schizophrenia.

In the simplest of terms, schizophrenia is a mental illness that distorts the way a person thinks. It is considered one of the most chronic and disabling of all mental illnesses and has symptoms like disorganized thinking, lack of motivation, lack of emotion and delusions, usually in the form of hearing voices or noises that aren't actually present.

Because of the nature of the delusions, the illness is often confused with other severe forms of mental disorders.

"I run across many people who think schizophrenia is dissociative identity disorder, or multiple personality," said Jean Harris, the director of the Antelope Valley chapter of the National Alliance on Mental Illness.

According to the National Institute of Mental Health, approximately 2.4 million American adults, or about 1.1% of the population age 18 and older in a given year, have schizophrenia. The institute also said schizophrenia often first appears in men in their late teens or early 20s. In contrast, women are generally affected in their 20s or early 30s.

Dr. Roger Girtan, a clinical psychologist at Antelope Valley Hospital, generally agreed with the institute's findings, particularly for men.

"Schizophrenia can have its onset during puberty, most often between the ages of 18 to 21," he said. But he also said, "Schizophrenia affects men and women with

equal frequency."

On the subject of a link between suicide and schizophrenia, experts are mixed as to whether schizophrenics are at a higher risk. As a whole, the National Institute of Mental Health claims that more than 90% of people who kill themselves have a diagnosable mental disorder.

According to the Center for Disease Control, "Persons with schizophrenia pose a high risk for suicide. Approximately one-third will attempt suicide and, eventually, about one out of 10 will take their own lives."

"Schizophrenics are more at risk for suicide than the general population," Girtan said.

"The lifetime risk of suicide for individuals with chronic schizophrenia is variously estimated at between about 9% and 15%, with the usual rate centering at 10%. That is much higher than the general population."

Carloita Childs Seagle, deputy director at the Los Angeles County Department of Mental Health, said that there are some who dispute a link because of influence from other factors.

"The nature of the link could be reasonably disputed because it may be due to environmental stress, mood dysregulation, impulsive-ness, loss of hope or something else such as hallucinations," she said.

In her experience, Laurie Ross, a clinical social worker at Antelope Valley Hospital's mental health unit, indicated that depression was of greater concern for suicide than schizophrenia.

"We see more people with depression at risk of suicide than schizophrenia," she said, though she also indicated those who realize they have schizophrenia are more at risk for suicide.

Harris attributed deaths among schizophrenics to accidents. "Suicide is not that prevalent in

Schizophrenia — According to the National Institute of Mental Health, about 2.5 million people in the U.S. are afflicted with schizophrenia. Findings from the Centers for Disease Control indicate the economic burden of schizophrenia is great during the first year, which suggests a need for improved monitoring upon initial diagnosis.

Depression — A state of low mood that can affect a person's behavior, feelings, thoughts and sense of well-being. Depressed people can show signs of sadness, anxiety, hopelessness, worry, helplessness, worthlessness, guilt, an irritable mood, hurt or restlessness. Other signs include loss of interest in activities the person previously enjoyed.

schizophrenia," she said. "It tends to be accidental. They stand much more of a chance to hurt themselves."

In addition to the suicide rate, schizophrenia can create an economic impact, especially as the reality of the diagnosis sets in for the patient.

According to the CDC, "The economic burden of schizophrenia is particularly great during the first year following the index episode, relative to the third year onwards. This finding suggests the need for improved monitoring of persons with schizophrenia upon initial diagnosis."

Judy Cooperberg, director of the Antelope Valley Enrichment Services office of Mental Health America, indicated that the Great Recession and home loss adversely affected the Valley's mentally ill community on a scale greater than other residents.

"The foreclosures definitely affected families," she said.

Despite the grim statistics, Cooperberg offered hope for those suffering from the illness.

"Schizophrenia is not a death sentence," she said. "In terms of medications, Ross

loss of appetite or overeating, problems concentrating, remembering details or possibly complaining or attempting to commit suicide. Insomnia, excessive sleeping, fatigue, achos or digestive problems may also be present. In the latest data from NIMH, nearly 15 million Americans suffer from depression and it is the leading cause of disability in the U.S. for ages 15 through 44. Studies from the Centers for Disease Control indicate depression causes 200 million lost work days a year and costs employers anywhere from \$17 to \$44 billion in lost productivity.

Bipolar disorder — A type of mental illness characterized by episodes of an elevated mood known as mania that alternate with

depression. According to NIMH, about 5.7 million Americans have bipolar disorder.

Places to get help
National Alliance on Mental Illness: Antelope Valley 44349 Lowry Ave., Suite 104, (861) 341-8041, www.nami.org/eisenhans:av
Mental Health America of Los Angeles: Antelope Valley Enrichment Services: 506 West Jackson St., (661) 726-2850, www.mhala-aves.org

Schizophrenia Anonymous — Wednesdays at noon, AV Discovery Resource Center, 1609 East Palmdale Blvd., Suite G. (661) 947-1595.
National Suicide Prevention Lifeline: (800) 273-8255.

said they are useful, as long as the patient takes them.

"Medications are often the most valuable resource, but people with schizophrenia can feel like they don't need it," she said, likening it to a non-cancer patient being told they need chemotherapy.

Harris added that schizophrenia have agnosia, a condition where people lose the ability to recognize objects, faces, voices or places.

Nearly every professional said family support is crucial in helping someone cope with schizophrenia.

"The first line of support is the family," Harris said.

"We want a facility in this area so that the families can be involved," Girtan said.

"Family involvement in helping individuals with schizophrenia can be a major resource in overcoming the consequences of the illness, which include isolation, demoralization, poverty, exposure to physical dangers and decline in health," Childs Seagle said. "Too often, families become overwhelmed and distance themselves from loved ones with schizophrenia."

Childs Seagle added that there are multiple agencies that can assist families and individuals cop-

ing with schizophrenia. "Skilled mental health professionals and support groups such as NAMI (National Alliance on Mental Illness) can help families offer the best possible help and lessen the emotional turmoil involved," she said. "Helping individuals with schizophrenia develop stability and reconnect with family can improve their quality of life. When that isn't possible, outreach and engagement of individuals with schizophrenia can provide comfort, lessen social isolation and make it more likely that further treatment will be accepted."

While Harris is appreciative of efforts by the county to help with services, the Antelope Valley chapter of the national alliance still is in its early stages.

"NAMI AV is so small, we don't get any grant money," Harris said, citing a \$15,000 annual budget. "The community still hasn't heard of us."

In lieu of extra funding, Harris said collaboration across multiple agencies will be needed to give services.

"We are going to need other treatment options available," she said. We need a collaboration

and work together to provide resources." An example of that hoped-for joint effort being discussed is a new treatment option called health neighborhoods, where patients can be treated for all outpatient health needs like substance abuse and mental illness.

"We want to address the needs of the whole person," said Dr. Robin Kay, chief deputy director for Los Angeles County Department of Mental Health. "We've been talking about it internally for years."

"The model design and location for health neighborhoods are in several county departments," Childs Seagle added. "DMH is currently in the process of working collaboratively with Los Angeles County Departments of Public Health and Health Services to map and connect DMH provider networks (children and adult) to public health centers, substance abuse disorder providers and health centers throughout the county, including the Antelope Valley."

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