ACHSA/Los Angeles County Client Coalition/Project Return: Peer Support Network Support for New MHSA Funded Community Integration Support Program

Dear Marv,

Attached please find a recommendation for the establishment of a new MHSA funded Community Integration Support Services program which is necessary to complete the current MHSA continuum of care. This recommendation has been endorsed by the ACHSA Board of Directors as its highest priority for new MHSA funding, and it has also been endorsed by the Los Angeles County Client Coalition and Project Return: Peer Support Network. Our recommendation for this new MHSA funded program was developed out of a workgroup ACHSA established to look at the functioning of Wellness Centers and was the suggestion of individuals with lived experience on that workgroup.

We are formally requesting that this recommendation will be included as part of the Departments' MHSA 3-Year Program and Expenditure Plan. It is consistent with comments you made at a prior ACHSA Board meeting about the Department's priority for building back up the adult system of care, which has been so decimated over the past number of years with funding reductions. We believe strongly that there can be no more cost effective program funded, as it will act as a lifeline for those returning to the community and prevent costly (both in human and financial terms) relapse/returns to the mental health system at the FSP level. This program model also includes a Peer Case Manager, which supports the important Department priority of consumer employment.

If it is necessary, we would be happy to have two of the members of our Wellness Center Workgroup, Greg Walston from San Fernando Valley Community Mental Health Center, and John Travers from Mental Health America of Los Angeles, be able to make a brief presentation before the System Leadership Team on this program.

We look forward to hearing back from you.

Thank you.

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Recommendation for Community Integration Support Services
New MHSA Funded Program to Complete the Continuum of Care

December, 2013

Problem Statement: After years of significant budget cuts to our core County mental health system, Mental Health Services Act funds were designed to fill many gaps in meeting the needs of unserved and underserved clients. While we today have a continuum of care which generally meets a significant portion of client needs and creates positive client flow, our system essentially stops at Wellness Centers, resulting in a gap in the continuum of care and a bottleneck there for those clients who just need ongoing medication management and brief case management visits. These clients are generally stable, may be with family or in permanent housing, and may be working part time.

While the original goal was to get clients to flow from Wellness Centers directly into the community and access private providers for their medication management services, this is realistically really only available today for a very small portion of clients. The fact is that there are not enough providers in the community who can or will work with these clients, as many clients have complicated medication regimes that primary care providers cannot properly manage. In addition, not all clients feel comfortable in going to a Wellness Center from which they have "graduated" to simply continue to receive medication support services. On top of this, and just as importantly, many clients who may be ready at some point to transition from a Wellness Center will, at a later point in time after their transition, require "check in" with a case manager to address non-medication related issues that arise once they have been integrated back into the community.

Historically, the County mental health system looked to community mental health agencies and County clinics as the place of choice for ongoing medication management and brief case management services for clients who are integrated into the community, have successfully navigated through the system, and no longer need more intensive services.

The decimation of these resources due to years of significant curtailments has led to two negative consequences today in terms of our current service delivery system: 1) it has severely limited the flow of clients out of Wellness Centers, which have been forced to become de facto med management/ brief case management clinics for these individuals, with fewer resources then available to dedicate to recovery oriented services for clients who are in moderate levels of recovery; and 2) it has meant that those clients who have transitioned into the community that may at some point start to decompensate will not have the resources they need to avoid having to potentially re-enter the system at a much higher level of care.

Accordingly, re-establishing some form of limited outpatient-type programming offering medication management and brief case management services to clients ready to transition from Wellness Centers should both increase the flow of clients from Wellness Centers, allowing them to concentrate on those individuals in moderate recovery for which they were designed, and provide clients who have transitioned back into the community with a "lifeline" necessary to prevent them from going back into the system at a higher, more costly level of care.

Recommendation: As the highest priority for new MHSA funding, DMH should complete the current MHSA continuum of care to include Community Integration Support services (see chart below), which would offer medication support and brief case management appointments to former Wellness Center clients to allow them to "check-in" on an occasional, as needed basis. Funded Community Integration Support staff would include a Psychiatrist or Psychiatric Nurse Practitioner (PNP) (either of which could provide services remotely), a Licensed Vocational Nurse (LVN) or Licensed Psychiatric Technician (LPT), and a Peer Case Manager.

Complete Continuum of Care