For Your Consideration

THE FAILURES AND SOLUTIONS OFFICIAL REPORT

Mother Advocates for the SMI, LAC

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INTRODUCTORY LETTER

Dear Drs. Ruiz, Sherin and Funk, Board of Supervisors, Los Angeles County and Mental Health Commissioners:

We are a group of concerned mothers, who all have sons with schizophrenia. We have a combined 65+ years of experiences dealing with every facet of the mental healthcare system, including failures which resulted in homelessness or incarceration. We represent thousands of others, devastated as much by the lack of quality resources, as the illness itself. We have critical information to share with you regarding the mental illness crisis in LA County, with an opportunity to turn it around and lead the way for the rest of the country.

As you are well aware, there is no part of the mental healthcare system which runs efficiently. There is a high rate of relapse, recidivism and tragic outcomes which could be preventable if long term, therapeutic housing and treatment were available to the most vulnerable. The lack of quality care has had an enormous psychological toll on our loved ones with serious mental illness as well as our families. It has also spilled over into society at large.

Our loved ones with mental illness have been turned away for treatment at Urgent Care Centers and community hospitals. When they do get admitted to these facilities, they are often under-treated and released without being stabilized, without an appropriate discharge plan or housing with services in which to return. We know you are also aware of how dismal and even dangerous the current state licensed Board and Cares are, offering little more than just one step above homelessness.

The grim realities are all around, but we as a group have chosen to focus our appeal to you in areas you have direct control over, namely: FSP, AOT, Urgent Care Clinics, the IMD's and the ERCP's. We know you have some leverage in the contracts you make with them. There is an urgent need for more of these programs, but with significant changes to their methods of care for better results, with particular attention needed to address those patients with Anosognosia.

As parents, our abilities to help are often rejected by mental healthcare providers, even when we have vital input to share which could change the course of treatment and improve both short term and long term outcomes. **At the very least, there needs to be more accountability and transparency by the providers with whom you contract.**

We feel there has never been a more informed Department of Mental Health and Board of Supervisors than the current assemblage, with the will and qualifications to make the big and necessary changes to our dysfunctional mental healthcare system. Our group of concerned mothers wants a seat at the table, and we are providing you with our labor of love: documentation of the current failures in Standards of Care.

We offer suggestions and solutions as well.

We look forward to collaborate in making improvements.

Mother Advocates for the SMI, LAC

Shelley Hoffman, Kartar Diamond, Anna Penido and Cheryl Perkins

PERSONAL STORIES

PERSONAL STORY # 1

My husband says it bluntly: serious mental illness is a death sentence. This is harsh. This is not hopeful. Yet, it is real.

My son started seeing a psychiatrist at 16. He was diagnosed with Anxiety, Depression, then and Major Depression. Earlier, we knew him to be generous, confident, ambitious, and witty. Now, despite regular talk therapy and ever-changing medications, he locked his door and barely spoke to us. He alienated his few friends and just wanted "to be alone." He did win a college Presidential Scholarship and graduate, but then struggled to find and hold a job.

He alienated himself from me for over a year. I found a family estrangement specialist in San Francisco to help me work toward reconciliation. I took the NAMI Family to Family class. My husband and I went to 2 NAMI support groups weekly. I went to Al-Anon. I kept reaching out to my son. No response. It was clear he was self-medicating with alcohol and marijuana.

He left the country. He had no income and was in terrible debt. He took no meds. I slept with my phone by my pillow. Finally, a call came from him. He was in Ecuador. He had fallen, was in a coma, and needed surgery. I flew to Quito the next morning. It wasn't a fall. He had jumped 50ft from a cable car. I was stunned. This was surreal.

After his surgery, I got him back home and into intake at LA County's Edelman Mental Health Center the very next day. Despite his suicidal condition, the wait-time to see a psychiatrist was a **month**; a social worker, 3 weeks. We did get a social worker appointment at Exodus in 2 weeks. My son described it as "an interrogation." The staff would not accept any information from me, let alone tell me anything about his condition. My son simply could not give an accurate rendering of what went on in the session or what to do in the meantime until a psychiatrist could diagnose him and prescribe meds in a 15 minute appointment in another 4 weeks.

My son was overwhelmed with extreme paranoia, depression and psychosis. He refused to let me take him to UCLA emergency, or even to a psychiatrist. He was sure the FBI and the CIA were after him, trying to poison him and steal his DNA, convinced his sister and I had "sold out" to them for $60,000.

I learned that the only way I could get my son diagnosed and on medication, involuntarily, was through police arrest. Imagine trying to get your own suicidal son arrested in order to save him. I feared I had no choice when he started threatening me physically, but when the police arrived, he was rational and they left, saying he was not an immediate threat to himself or others. They were not trained to make this medical decision.

My son left by Uber before the County's social worker team could arrive. I learned later that at any hour, **there were only 2 such teams for all of LA County**---how naïve of me to think they could get there in time! Learning he was back in Ecuador, I researched its rules on hospitalizing an unwilling, mentally ill person in crisis. They, too, incarcerated first. I found a psychiatrist in Quito who spoke English and stood ready to diagnose, medicate, and help. But my dear 30 year-old son was convinced the doctor had sold out to the FBI. He got a knife and attacked the father of his former girlfriend. He remained isolated.

I sent him sustenance money, but he wouldn't come home. He told me how hard it was to go to a different food stand every day so "they" wouldn't know which food to poison. But he knew how to fool "them." He would stop eating.

The US Embassy called to say they found my son "emaciated," curled on the floor next to the unlighted gas stove he'd left on. He was sent to the hospital but pronounced dead. He saw no hope at the end of the tunnel of what he must have perceived was a chronic, fatal disease. How could my son (and our family) have had so few options in this rich country? Simply no life ahead?

Until we revise HIPAA laws, involve families, create a pipeline of social/psychiatric services, remove the mentally ill from the criminal justice system, incentivize young doctors and psychiatric social workers to meet the drastic life or death need, and until we demand true parity between mental and physical illness, SMI sufferers will continue to endure a living death, or simply die.

C.D.

PERSONAL STORY #2

Without hesitation, I joined an advocacy group of mothers who have sons with schizophrenia. We each have experienced horrific forms of neglect for our sons by local providers. We are desperate to instigate positive change and accountability.

It is no secret that our seriously mentally ill loved ones suffer enormously; however, we family members also suffer in silence, especially us mothers. Will an all-female L.A. County Board of Supervisors make any difference in the decisions which hurt or heal our families? Will a female-dominated staff at the Department of Mental Health better empathize with our plight?

The fall-out in my family has spilled over into every area of life. My spouse left me over the stress caused, specifically by the mistreatment and lack of treatment for my son's mental illness. I also developed hypertension and anxiety over the inexcusable circumstances my son and I had to deal with. The professional betrayals were so frequent and absurd that I had to question my own sanity at times.

The economic toll, if not the psychological toll, on family members should be included in all the county budget concerns. I ask you to please take the long view on how inadequate mental healthcare not only prolongs the suffering of those with SMI, but how it also deteriorates the family members as well. We are taxpayers and when we can't perform at work or maintain our businesses because of the overwhelming grief and constant crises which we handle alone, without professional support or resources, it stretches us to the limits where we may *also* become a "burden" to society.

Thank you in advance for taking the time to read our report and treat the understaffed and underfunded mental healthcare system for the public health emergency that it is.

K.D.

PERSONAL STORY #3

My son, who at 19 years was a National Merit Scholar at UC Berkeley, is now 40 years old. He has schizoaffective disorder; since having to leave college, he has participated in a number of programs and resided in a series of Board and Cares, sober living homes, step-downs and IMD's, and has been **hospitalized 21 times.** There are not enough appropriate therapeutic residential settings for people with serious mental illness, so we have had to accept the unacceptable. These unacceptable conditions are bad for my son, who suffers the indignity imposed on him, and makes his condition worse. His dental and gastrointestinal needs are made extremely difficult. Even as a knowledgeable advocate, I also suffer greatly witnessing his plight.

In the early years of my son's illness, our whole family was traumatized. I was very concerned for my two younger children. When my youngest began to act out in middle school, we had him tested and realized we had to reduce the stress in his life. Our middle child, off at college, announced she would not be returning home if the oldest was residing there. My husband and I were alienated from our friends. Marital rifts were rubbed raw. We could not allow our oldest to continue to live at home and hold the rest of the family hostage to his moods and behavior, but it pained me greatly to not allow him the comfort of home.

In the twenty years since my son became seriously mentally ill, I can say that the situation is worse. I have witnessed the closing of psychiatric departments of hospitals. Cedars-Sinai closed its psych unit and built a cardiac unit – because running tests pays the bills, but there are no tests for psychiatric patients. UCLA Resnick does not take Medi-Cal patients. Board and Cares have closed because the reimbursement rate is so little that they cannot survive, let alone provide adequate staffing, programming and an uplifting environment.

Because of the poor quality and lack of supervision, my son did not do well in a couple of Board and Cares. There was a murder at one of them. There were rampant bed bugs and neglect at another, all were what you'd call "dumps." He would decompensate and then need to be hospitalized.

My son has resided now for 3 years at an IMD, without a patch of green on the property, only an internal concrete courtyard. He feels like a prisoner, although he has not committed any crime. With Covid, there is no visitation or passes allowed, not even zoom calls allowed since March! Can you imagine turning 40 in such a setting? Anyone would "go crazy" in that environment. I am his conservator but I can't find a decent place for him that does not cost a fortune. And I live with the nagging guilt that pops up several times a day knowing his very restricted and poor quality of life.

Understandably, my son is very angry that he is in this situation, but we are left without appropriate options. The stress weighs heavily on me, and we all know that too much stress is bad for health.

S.H.

PERSONAL STORY #4

I'm not sure you know what it's like to have not one – but **two** children – with severe mental illness.

From one day to the other your life is brutally interrupted. All dreams you have for your children and yourself are gone. You are forced to look at the new film of your life that says:

"Hey, you won't ever see your kids smiling again. They won't graduate, they won't be able to work, they won't get married, they won't have kids, you will not be a grandmother, and you won't be able to go back to your career. Are you sad? Swallow that sadness. No time for grieving. Prepare to fight. From now on your life is fight, fight, fight. Fight for your sons to have decent treatment. Fight against all the "no's" that the mental healthcare system and laws created that make your life even more difficult."

This is what I heard from the Providers:

P: NO! You can't see your son – not even through Zoom. We don't have enough computers, we don't have enough staff.

Me: But he is not a criminal! I have not seen him for a whole year! Everyone in Covid times has the right to talk to family! It is a human right! I can bring a computer.

P: NO! He can't have a computer. NO! He can't have a cell. **HIPAA laws**. He needs to sign up for the 5 minutes on our single phone for 60 people.

Me: But he can't remember. He has severe cognitive impairment.

P: Sorry, we can't do anything about it.

Me: Can you transport him to the dentist?

P: NO! He can't go out to the dentist unless our IMD dentist examines him first, but since your son won't allow examination, we can't force him. We wait. Maybe when the pain becomes unbearable he might change his mind!

P: NO! He is not entitled to any outing until he attends groups.

Me: But he doesn't understand!

P: Sorry, that's the rule. No groups, no outing. Some people have been here 10 years and have never put a foot out.

How the Stress Provoked by the System Damaged my Heart:

My oldest son, just admitted to UC Berkeley, was discharged too quickly from the hospital. He threw his medication off in the first trash bin, then threw all his belongings out, just kept a phone, and became homeless in San Francisco, a town he did not know.

How can a mother's heart resist being glued 24/7 to the phone navigating her psychotic son through the streets in search of a shelter before night arrives, because he was discharged too soon? How can a mother's heart stop racing when he finally asks for help to return to LA and finally agrees to see a psychiatrist but is denied treatment because he won't sign a release even though he is obviously psychotic?

How can a mother's heart withstand after relentlessly driving her son around town with the risk of him jumping out the door going from Exodus, to Didi Hirsch, to the ER of Southern California Hospital and only getting a NO?

I couldn't take it anymore. Right there at the ER lobby I started screaming like a crazy person. I couldn't stand the torture I was going through. A torture inflicted by a system that gives more importance to a signed piece of paper than giving treatment to a human being in extreme suffering. It was a chance in a million to get my son to the hospital door and that chance was lost. Two months holding his life on a thread and all lost because of a stupid rule. I had a nervous breakdown, my heart got arrhythmia. I could not breathe. My son freaked out and darted off to the streets while I was wheeled into the ER.

My oldest son lost 2 years of his life left untreated living at a SHARE home under the "care" of FSP contracted Telecare. What care? **They never got him hospitalized even when he stated many times he was suicidal. I had to step in despite Telecare's hostility to family and force a 5150.** My adrenaline skyrocketed when Exodus Urgent Care tried to discharge him because he had an address and was enrolled in FSP/Telecare. I had to raise my voice and threaten until they "found" a previously non-existent hospital bed.

At Pacifica hospital I had to raise my voice again and threaten again as they wanted to discharge my son because he refused medication. I had to scream to get the Reese Hearing Court evaluation. My son improved and was about to be discharged but did not like the options of Board and Cares offered to him as he was not allowed to cook his own meals. I couldn't believe my ears when I heard the most irresponsible and ignorant statement I have ever heard from a mental health worker:

"Your son has the right to be homeless!" (Social worker, Pacifica Hospital).

Why mental health workers, doctors and courts are insensitive to the beating, abuse, hunger and human degradation that our sons suffer on the streets, when discharged too early and not placed in a proper treatment home? The answer seems to be just one: Because it is not their son!

My heart has been under stress over and over again for 12 years. Stress after stress turned a minor heart murmur into major heart surgery. While at the ICU I had another blow. My youngest son was eager to visit me but suffered a psychotic break in the lobby. I was shocked to know that the fancy Cedars-Sinai hospital where I was did not have a psychiatric unit!

My heart was ripped open again – now by the pain of not knowing where they would take my son.

My sweet youngest son went through 22 hospitalizations and has been in locked facilities for 7 years. My heart breaks at every birthday. Seven birthdays, seven Thanksgivings, seven Christmases seeing him locked up. My heart breaks as I can't even take a photo with him because of HIPAA. He is never allowed any outing because he doesn't attend groups and has not reached the level that allows prizes. They see him as "stubborn," not "severely mentally ill". They ignore that his reward system is broken. They ignore the neuropsychological results that prove his severe cognitive impairment.

All those years I have faced blows in my heart at every "no". NO to ABA therapy, NO to music therapy, NO to computer, NO to outings, NO to exercise in open air, NO to vitamins, NO to cell phone, NO to Zoom with family, NO to a chance of having a Life!

In a system that does not provide stability for the patient or caretaker, I was forced to become the case manager, the medication manager, the driver, the nurse, the security guard, the advocate, the coach... it was impossible to keep a full-time job.

I had never imagined that as a person with a Masters' degree I would need food stamps one day. I was forced to take the "unpaid job" of keeping my sons alive.

A.P.

PERSONAL STORY #5

So many times I have driven darkened streets looking for any sign of my only son asking God to allow me to see him again. Praying that some sane person wouldn't harm him for boldly talking to the invisible. Imagine having to flag down a law enforcement officer because you can see your beloved child deteriorating before your eyes, praying all the while that they would deal with him compassionately and that you have not just put them in harm's way. Imagine how incredulous and pained you would be to hear your spouse and partner in this struggle share his plans to move out with your youngest child because he can't cope anymore, she is withdrawn, and because of your consuming pursuit of the solution that will make your broken child well.

Every ounce of your energy is spent in defense of your child from the outside world, within the system meant to treat them, and even in your own home. If you triumph in the struggle to get your beloved and psychotic child admitted to a facility you tell yourself that they are safer and you take solace in that until you can't anymore. Your employee health care plan will send your psychotic child home because the insurance dictates the length of treatment. Never will it be long enough to secure the conservatorship that will force HIPPA to stand down. With county contracted facilities, the risk of assault looms greater. My beautiful son who would give you the shirt off his back has been assaulted multiple times and had his jaw broken at an LACDMH Mental Health Center.

You rack your brain trying to find a way to get them out of this maddening cycle of returning to institutions where patients in varying states are herded together, where physicians ignore hard won conservatorships and proceed with treatment without conferring with you, where therapy is nonexistent, where the environments are often either chaotic or catatonic, and where there is no treatment plan for optimal functioning and everyone is on this pharmaceutical universal treatment plan.

I have worked for years to turn my own home into a residential facility to house those with developmental disabilities. I have worked two jobs to meet the certifications and have given up my home. Only then will I be able to pay for the 24/7 supported and safe living that Board and Cares fail to provide someone like my son. I want to assist others like him by creating a safe and restorative environment. It is a daunting task and perhaps the only area where I can bypass the bureaucracy that prevents the life saving measures from reaching the severely mentally ill. This constant state of lack, degradation, and reoccurring heartache cannot have the last word.

C.P.

PERSONAL STORY # 6

This has been the most painful experience in my life, with the pain compounded by the fact that it will never end. Maybe my son will get better or even “recover,” but he will always be vulnerable and need help and protection.

Before my son became ill, I felt the incredible freedom of having had success in my profession. I had friends and family, had grown beyond materialism, had expanded my viewpoint into other cultures from travels, and matured to be able to offer help and wisdom. I thought my son would be on his own path, have a good life, and I felt my own life fulfilled. I could leave this planet and it would be okay, nothing to keep me here.

But now I must stay here to make sure my son can survive. There is no other family. My search for who will care for him when I’m gone has not yet been realized. I feel that is what I must achieve, yet I have no answers. The brief time I enjoyed the freedom to leave is gone and I am trapped in this life. Although I have accepted what is and made the appropriate adjustments and have many moments of pleasure and interest, the pain and disparity is always there. And being a realist, I know it will never go away.

This phenomenon comes as the result of being faced with a loved one whose life was taken out from under him, and being stranded for help and support from a disorganized, inadequate mental healthcare system. Because of confusion and the lack of resources readily available for his treatment, his father and I spent hundreds of thousands of dollars for private care. We knew he needed to be conserved and paid to have it done privately.

One of the most shocking incidents came one day in Mental Health Court. He had been conserved for only one year, but at his renewal the judge refused to continue his conservatorship, even when my son’s psychiatrist told the judge in person that my son was not ready to have his conservatorship end. In fact, my son was making slow progress at a private residential program and the director of that program also came to court to say that my son still needed to be conserved.

She must have been impressed that my son looked clean and dressed well for his appearance in court. She must have also believed his delusions, including his claim that he could financially support himself, without verifying if that was true. But there is no excuse for her disregarding his comment that he planned to heal himself by taking a trendy psychedelic called Ayahuasca. Stunned when the judge said she would not renew his conservatorship, the predictable results quickly followed. My son demanded to leave the residential program that had been helping him and refused to take his medication.

I no longer had the power as his Conservator to mandate his care. Months later, he became gravely ill again, requiring hospitalization. We were back to Square One. It was worse than that, however, because each relapse makes it harder for a mentally ill person to regain stability. Where would my son be now if his conservatorship had been renewed and he had continued to heal without interruption?

How many people have died from the naïve and uneducated decisions these powerful individuals have over our loved ones’ fate?

I see now that both the private and public mental healthcare systems lack in understanding the extent of the disabilities and potential set-backs suffered by those with severe mental illness, as well as the suffering of their families.

P.B.

THE REAL COST OF CYCLING FOR ONE INDIVIDUAL

Date from	Date to	Name of Place	Type	Cost to LAC *
8/15/2000	11/25/2000	UC Berkeley	Indep. Living	
11/25/2000	11/30/2000	UCLA	Hosp	
11/30/2000	12/14/2001	Grandparents & Home	Home	
6/1/2001	11/8/2001	UC Berkeley	Indep. Living	
11/8/2001	11/19/2001	Alta Bates	Hosp	
11/19/2001	12/17/2001	STEPS	Rx Facility	
12/17/2001	12/20/2001	Annacappa Hospital	Hosp	
12/20/2001	4/3/2002	River Community	Rx Facility	
4/3/2002	9/29/2002	Miracle House	Sober Living	
9/29/2002	10/8/2002	UCLA	Hosp	
10/11/2002	1/11/2003	Millenium House	Sober Living	
1/11/2003	1/17/2003	Home	Home	
1/17/2003	2/13/2003	Jump Steet	Rx Facility	28 days x $ =
2/13/2003	4/1/2003	Harbour House NH	B & C (treatment?)	
4/1/2003	4/8/2003	Sepulveda West B&C	B & C	
4/7/2003	4/11/2003	Northridge Hospital	Hosp	4 days x $ =
4/11/2003	1/26/2004	Home	Home	
1/26/2004	2/2/2004	Pacific Hospital in Oxnard	Hosp	7 days x $ =
2/2/2004	2/28/2004	Harbor View	B & C	
3/1/2004	1/17/2005	Home		
1/17/2005	2/23/2006	Step Up on Second	B & C	
2/23/2006	3/2/2006	Brotman Hospital	Hosp	8 days x $ =
3/3/2006	7/19/2006	UCLA	Hosp	136 days x $ =
7/19/2006	3/25/2008	Meadowbrook Manor	IMD	448 days x $ =
3/25/2008	7/1/2008	Anne Sippi	Step Down	96 days x $ =
7/1/2008	1/15/2010	Pasa Alta	B & C (still ASC enrolled)	195 days x $ =
1/10/2010	6/10/2010	Apartment in Santa Monica	Indep. Living	
6/10/2010	6/25/2010	Del Amo Medical Center	Hosp	15 days x $ =
6/25/2010	5/7/2011	The Manor	B & C	
5/7/2011	5/14/2011	UCLA Harbor	Hosp	
5/14/2011	3/?/2012	Graduate House	B & C	
8/9/2011	8/31/2011	Silverlake Medical Center	Hosp	
3/?/2012	6/9/2012	Beverlywood Manor	B & C	

6/5/2012	6/7/2012	UCLA Harbor	Hosp	2 days x $ =
6/7/2012	7/5/2012	Del Amo Medical Center	Hosp	28 days x $ =
9/14/2012	10/8/2012	Silverlake Medical Center	Hosp	24 days x $ =
11/20/2012	1/14/2012	St. Francis Medical Center	Hosp	54 days x $ =
?/?/2012	?/?/2012	Percy Village	Step Down	60 days x $ =
2/14/2013	2/25/2013	Del Amo Medical Center	Hosp	11 days x $ =
1/19/2013	7/16/2013	Cedar Street	Step Down	207 days x $ =
7/3/2013	7/10/2013	Silverlake Medical Center - Ingleside	Hosp	7 days x $ =
7/10/2013	8/15/2013	Walker's Board and Care	B & C	
8/15/2013	8/20/2013	Del Amo Medical Center	Hosp	5 days x $ =
11/3/2015	11/23/2015	East LA Doctors Hospital	Hosp	20 days x $ =
11/23/2015	12/23/2015	Aurora Las Encinas	Hosp	30 days x $ =
12/14/2015	3/24/2017	Anne Sippi	Step Down	456 days x $ =
3/22/2017	6/30/2017	Southern Ca Hosp at Culver City	Hosp	97 days x $ =
6/30/2017	1/7/2019	Harbor View	IMD	552 days x $ =
1/7/2019	2/12/2019	UCLA	Hosp	
2/12/2019	Present	Harbor View	IMD	640 days x $ =
*** Highlighted in yellow are the places where LAC accrued costs.**				
Facilities not covered by LAC were paid for privately.				

STANDARDS OF CARE AND QUALITY OF LIFE SERVICES

The family members contributing to this report have had alarming experiences with mental healthcare providers, where **Standards of Care** were noticeably lacking, ambiguous or not consistent from one service provider to the next, such as two IMD's having different policies.

Quality of Life services have also been lacking, including at the most basic levels, such as tracking Activities of Daily Living (ADL's) by providers who should be delivering a higher level of care and supervision.

We understand that there will be differences in expectations and standards of care provided, depending on whether a person is in an out-patient program or a locked facility.

We will address in this report, the agencies and providers with whom DMH has contractual agreements. We need more oversight and accountability with these providers. We hope there can be improvements at every level for both humanitarian and therapeutic reasons. There can be financial savings as well when relapse and recycling are reduced through more effective, comprehensive and long-term care.

Some of the failures have been similar among all types of providers, while others are specific to the level of care or individual facility. We will give examples based on our actual experiences, but we know the list of failures (and solutions) could be expanded.

URGENT CARE CLINICS

When a person in crisis comes to an Urgent Care Clinic, the type of treatment they get may prevent a hospitalization or it may precede it.

Some of the failures of Urgent Care Clinics:

- ❖ Not enough clinics to handle the volume of people who need them
- ❖ Rigid 24-hour or less criteria for discharge (BeWellOC.org offers up to 90 days' stay)
- ❖ Refusal to treat voluntary psychotic patients if they don't sign a form to be treated and not considering verbal consent or obvious symptoms as enough evidence.
- ❖ Staff not receptive to relevant medical input from family members.
- ❖ Incidents of patient dumping, discharging to streets when no beds available at hospitals or patient is enrolled in FSP.

SOLUTIONS:

- ☑ Provide communities with more Urgent Care Clinics and larger capacity to hold people for more than 24 hours. This could help with the overflow at the actual area hospitals.
- ☑ Provide a patient-staff-family member **liaison** for better transmission of pertinent information.
- ☑ Accept verbal consents for treatment from voluntary patients.

FSP: FULL SERVICE PARTNERSHIP PROGRAMS

Voluntary FSP programs have the potential to prevent episodes of instability and hospitalizations, but frequent failures with FSP providers have also allowed clients to drop out prematurely, devolve further into grave disability or danger to self and others.

Some of the failures of the FSP Programs:

- ❖ Not enough FSP programs, sometimes tragic outcomes while on a wait list for help.

- Because the program is stretched so thin, the FSP team cannot always provide extra support in a timely manner when the patient is in crisis.
- FSP therapists and social workers with credentials to authorize the 5150 cannot utilize it due to lack of hospital beds (or an Urgent Care Clinic with expanded capabilities).
- Staff prioritizing perceived patient's rights (not wanting to be hospitalized) over calling for a 5150 due to grave disability and/or danger to self or others.
- FSP team drops clients who refuse help, even when obviously gravely ill.
- Due to lack of FSP programs, the client's frequency of care is reduced before they are ready (such as from weekly visits down to monthly visits)
- Rejection of family collaboration and observation, prioritizing the client's psychotic statements about his health condition.

SOLUTIONS:

- ☑ Provide **more funding for more FSP programs**, a quicker turn-around time between application and initial outreach.
- ☑ Since FSP is voluntary, **MHSA** needs to allocate more funding for it and **prioritize SMI people.**
- ☑ Empower FSP team to have a quick and seamless transfer from FSP to AOT when needed.
- ☑ Expedite the transfer of services when client moves to another city in Los Angeles County. (The waiting list forces the client to take a very long bus ride to their old service area, or remain 3 months without access to the local service area psychiatrist).
- ☑ Allow clients to keep their FSP team even when they move out of the Service area, if it is in the best interests of the client.
- ☑ Create MHSA-funded, **DMH-Residential facilities**, to supplement the lack of state licensed Board and Cares (and to exceed the QUALITY of services at the typical Board and Care) **This is a critical feature to stability** as many SMI people live in environments which undermine the care they receive from FSP.
- ☑ Support **improvement of existing Board and Cares** so they do not close or foster relapses. Develop criteria for their improvement.

AOT: ASSISTED OUT-PATIENT TREATMENT

AOT takes the FSP program to a higher level, for those less compliant, where court-ordered treatment has been effective for some people on a serious downward trajectory. However, participation in AOT is often not adhered to and clients still end up hospitalized or incarcerated during or after AOT involvement..

Some of the failures of the AOT Programs:

- Not enough AOT programs to handle the volume of those in need.
- Court-ordered treatment plans not adhered to have no consequences.
- Not the fault of AOT, lack of safe and therapeutic residential options undermine any progress they do make with clients.

SOLUTIONS:

- ☑ Mandate more **MHSA funds for more AOT programs**
- ☑ Mandate more MHSA funds for safe, therapeutic, **long- term** Board and Care housing. This is also critical for SMI people to get services they need where they live as many do not have reliable transportation options. More input on ideal, optimal long term housing follows.
- ☑ Provide an incentive for those who resist complying with AOT treatment.
- ☑ End the practice of using contractors for low-income housing who charge excessively high fees for their work. Charging hundreds of thousands of dollars per unit is making contractors rich at the expense of the vast number of mentally ill people who need housing.

IMD: INSTITUTE OF MENTAL DISEASE (LOCKED FACILITIES)

The IMD Standards of Care and Discharge criteria have been the most ambiguous and unavailable for review by involved family members, even when they are the Conservator. By the time someone ends up in an IMD, there has often been a long history of failures with voluntary programs, and yet there are still many aspects to the IMD experience which are not therapeutic and resemble warehousing.

This is unfortunate on many levels, not the least of which is that this is the end of the road for many low functioning people with no insight. In a locked setting, this should be the best time to prompt more self-reflection and cooperation through various innovative therapies, incentives and treatment modalities, which are currently not provided.

Some of the Failures at the IMD facilities:

IMD's often continue with the same ineffective, warehousing experienced at the hospitals the patients come from, which includes:

- ❖ Lack of ABA therapy and ADL prompting and assistance with personal hygiene, inappropriate behaviors, impulse behavior and elopement.
- ❖ Lack of nutritious food to help stabilize moods, overall health and dealing with side effects of medication.
- ❖ Unnecessary medication changes or additions to comply with "patient progress report" required by DMH, instead of implementing proven alternatives to medications which are just as effective for mental health without negative side effects.
- ❖ Lack of structure and staff to be outdoors in fresh air or partake of any exercise or physical activities.
- ❖ Lack of social, creative and therapeutic activities which the patients would participate in.
- ❖ Environments which do not let family members spend relaxed, quality time with the IMD patient.
- ❖ Lack of computers and phones for patient use. Policies undermine communication with family (with intensified restrictions due to Covid).
- ❖ Policies which inhibit a family member from discussing the patient's treatment program or problems.
- ❖ Uncooperative staff with regards to additional support offered by family members, be it nutritional supplementation or allowing an outside therapist to come in and work with the patient. (For example, even an orchid delivered to a patient who contracted Covid at the IMD, was denied).

- Sheer lack of IMD’s translates to patients languishing in community hospitals for excessive times waiting for an IMD opening

Standards of Care failures in IMD’s also include:

- Psychiatrists refusing to communicate with conservators or honor their legal rights, especially regarding medication and other medical needs.
- Lack of collaboration between medical doctor and psychiatrist.
- Lack of licensed therapists for all patients, regardless of health insurance.
- Ambiguous discharge criteria.
- Expecting the same performance from all patients. Not considering the wide spectrum of disability which profoundly affects compliance or advancement by the patient.
- Staff making documentation mistakes or consciously falsifying records, but unwilling to make corrections when confronted.
- Literal physical and verbal abuse by staff towards patients.
- Punitive, non-therapeutic measures taken when a patient is violent or dangerously psychotic.

SOLUTIONS:

Administrative

- ☑ DMH to include incentives in their contracts with IMD’s to provide a higher quality of care.
- ☑ Regular DMH oversight regarding IMD compliance with contract guidelines.
- ☑ Reduce to the optimal number of patients handled by one psychiatrist, increase frequency of visits and the time for observation, consultation, progress notes.
- ☑ Train all staff for a higher level of care and respect for patients, including the Dr. Amador’s L.E.A.P. method and Psychiatric Rehabilitation programs published by Dr. Robert P. Liberman.
- ☑ **Physically improve facilities** to allow for such additions as outdoor recreational space, quiet private visitation spaces for family, and non-punitive quiet spaces for patients under stress instead of forcing more medication IM’s and paranoia-exacerbating isolation rooms.
- ☑ DMH to request that Patient Progress Reports measure the whole person’s well-being and not only medication metrics.
- ☑ A plan by **DMH to create their own IMD’s**, especially since it appears the current IMD’s have a monopoly on patient admissions and a business/profit model taking priority over a recovery model.

Treatment

- ☑ More individualized nutrition plans allowed, higher quality of food, and **special dietary needs**.
- ☑ Perform **pharmacogenetic testing** and blood work for every patient with follow up recommendations: dietary, physical therapy or medication adjustments.
- ☑ **ABA Therapy** (positive reinforcement, repetition, prompting) to facilitate the development of organized language, positive coping skills and social behavior.
- ☑ Patient access to various technologies (**personal cell phone or use of computer**) within the IMD to communicate with approved people and maintain crucial relationships for their mental health.

- ☑ Access to computers can also provide many avenues for vocational training, **cognitive function exercises, c**reative pursuits and coaching.
- ☑ Allow regular frequent **outings for low-functioning patients** and given credit for it as an accomplished activity and not just a reward.
- ☑ DMH to fund **extra staff and transportation for outings** if providers complain about lack of staff.
- ☑ Establish relationships with outside non-profits and agencies like the Painted Brain and Harmonic Changes Music Therapy who can provide more creative, therapeutic and vocational training on site.
- ☑ Improve the **Shared Bedroom accommodations** for more privacy as well as more shared interests with roommates.
- ☑ Allow family members to participate in the treatment and discharge plan.

Psychiatrists

- ☑ Psychiatrists to honor Conservator rights and communicate with them. Disciplinary action for those who do not.
- ☑ **Consequences for doctors and staff** who violate policies and mental healthcare laws.
- ☑ Disciplinary action for psychiatrists who financially benefit from their relations with pharmaceutical companies.

ERCP: ENHANCED RESIDENTIAL CARE PROGRAMS (FORMERLY STEP DOWNS)

After discharge from an IMD, or as a residential option secured for clients by AOT, the ERCP is a chance to monitor and assess a person's ability to live in an open setting and maintain a level of stability that they did not have before. The ERCP is where residents often begin to relapse and don't get the support they need. The alternative is that the patient may do relatively well while in the program, but relapse soon after the discharge.

Some of the failures of the ERCP-Step Down programs:

- Residents often decline participating in programs, with no consequences or alternative innovative options.
- The facilities are in unsafe, crime-ridden neighborhoods where residents have easy access to drug dealers and liquor stores.
- Drug trafficking goes on within the Board and Cares, even with staff aware of it.
- Lack of communication between ERCP staff and the AOT personnel with family members and conservators.
- Lack of supervision and assistance with ADL's and other activities needing self-motivation like doing laundry.
- Unhealthy food and depressing living conditions, contributing to residents not staying on the premises for programs offered.
- Not allowing new residents to leave the facility to walk around the neighborhood for the first 2-4 weeks when the program could provide an escort and build trust.

SOLUTIONS:

- ☑ Improve the safety of the residents with competent **security staff**, and more ERCP's in better neighborhoods.
- ☑ Have ERCP's just for those in an AOT program or recently discharged from the IMD, instead of allowing these programs to exist within "regular" Board and Cares. Those living long term in the Board and Cares often provide negative or undermining examples for those required to be in day programs.
- ☑ Provide family therapy and programs geared for a successful discharge plan when patients are likely to resume living with family members or other residential options outside of the family home, with the mutual goals for recovery and stability.
- ☑ Provide activities to meet the **individual needs and level of functionality** for each patient. Higher-functioning people should be provided with job skills training or even actual jobs.
- ☑ Invest in the physical ERCP locations for **more welcoming accommodations**, such as landscaped outdoor spaces and well-maintained indoor recreational outlets, art and music therapy rooms, etc.
- ☑ A discharge plan that includes a long-term residential program option which can meet the needs of the patient **all under one roof.**

SUMMARY

It becomes obvious that many chronic problems and dysfunctions within the mental healthcare system are rooted in funding deficiencies and/or the lack of innovative and flexible treatment plans.

- Lack of priority in providing ***More of Everything***: Urgent Cares, FSP, AOT, IMD's, ERCP's and stable, safe long term, supervised housing.
- Lack of continuum of care for those who need support much longer or indefinitely.
- Lack of universally well-trained, communicative and sympathetic staff.
- Non-therapeutic environments and policies at every stage which can undermine any progress that is achieved.

As stated before, we know that each level of care is currently bound by certain policies, laws or financial limitations. However, there are some improvements which could be made across the board, no matter the level of care or provider, which DMH might be instrumental in facilitating.

Examples of "best practices" which could be implemented broadly include:

- Education and exemptions from the draconian **HIPPA laws** which prevent family members from being more involved in their loved one's care. Perhaps a patient could sign a release which will travel with them from one provider to the next, giving over-riding permission for family to communicate with staff.
- DMH could create a **web portal**, where patients and caretakers can report their experiences with any facet of the mental healthcare system, so that DMH and all concerned parties can have candid reviews and more accurate feedback regarding what is working and what is not.
- We know that DMH visited Trieste, Italy to better understand what works in their system. Whether it be in IMD's, ERCP Step Downs, or long-term residential care, there are also optimal **Recovery Models** which DMH can use as a resource if they have not already: including SHARE Collaborative Housing (L.A. County) if it were to have **full time, live- in trained support staff**, Psynergy (Morgan Hill, CA), and **especially the John Henry Foundation** (Santa Ana, CA).

FAILURES AT CONTRACTED SERVICES

STORIES: URGENT CARE -1

When the SHARE Collaborative House evicted my son, I arranged for the PET Team to evaluate him. They promised to get him hospitalized (5150), but he ended up at an Urgent Care instead.

I pleaded with them to get him hospitalized and to not give him any oral medication as I knew he would not take it appropriately. They said they could not do an injectable. After speaking with the treating Psychiatrist at the Urgent Care Clinic, giving her the whole history of my son's grave status, she agreed he should be hospitalized.

Staff was rude on the phone and threatened to report me to Adult Protective Services because I would not pick him up. A Supervisor later told me in a conciliatory way that he would "take care of the situation."

I received no further calls until the fourth day when a Good Samaritan called me to let me know that my son was wandering around her neighborhood looking ill and disoriented.

When I reached my son, I found him disoriented and dehydrated. In his back pack there were 4 nearly empty bottles of anti-psychotics. He told me that the Urgent Care gave him a script with orders to fill it at the drug store across the street, (which he did,) and a bus token to get back to Skid Row, but he got lost.

My son had overdosed on almost a month's worth of four different medications. Days later I reported this incident of extreme negligence to Dr. Roderick Shaner, then Medical Director of DMH, who helped my son get fast tracked into the AOT program, while stating that he really should be in acute care.

- FAILURE by Urgent Care Clinic to provide appropriate and responsible care for patient in crisis.
- FAILURE of Urgent Care Clinic to abide by the assessment of their own psychiatrist.
- FAILURE of UCC to notify the mother her son was discharged.
- FAILURE of UCC to prevent patient from taking a prescription inappropriately, even when warned by parent that patient could not be trusted to take oral medication correctly on his own.

STORIES: ERCS -1

I let the nurse know that my son was allergic to Clozapine. As Conservator, I had asked that medication changes be discussed with me prior to prescribing. The psychiatrist, however, would change my son's medication and then afterwards let the nurse advise me of the change. When I returned from a vacation, I found out that my son had been put on Clozapine. I told them to discontinue immediately. This could have been fatal.

One time, my son poked another resident in the back of the neck with a pencil. Although definitely wrong and could have been harmful, no skin was broken nor was there any need for medical attention or even a Band-aid.

They hospitalized my son after this, and then I was called on a Friday afternoon to be told that my son had to leave the facility within 3 days, due to a zero tolerance for “violence.” This was a devastating disruption for my son and his care. This was a place with a therapist he liked.

- FAILURE of nurse to document in patient's chart a life-threatening medication allergy.
- FAILURE of Psychiatrist to check patient's chart prior to medication change.
- FAILURE of doctor to respect Conservatorship.
- FAILURE of Enriched Board and Care's Program Director to provide continued care due to a non-violent act easily resolvable with counseling, anger programs, and going over facility rules.
- FAILURE of IMD to honor conservatorships and involve family members in treatment plan.

STORIES: ERCS -2

My son said disrespectful things to staff and residents, and after a time, they gave him a 30 day notice. His case manager expected me to find him a place, perhaps a Board and Care. I believed that if he wasn’t doing well at a Step Down, then a less restrictive placement would certainly not be good.

I advocated to the DMH Office of Consumer and Family Affairs that he get a lateral transfer to another Step Down. During the period when two Step Downs would not take him, and others were inappropriate, the case manager changed, and my son remained at Anne Sippi Clinic (ASC) for another 6 months.

One day, my son called home stating to his dad that he was suicidal. His dad called ASC and they had him hospitalized. The hospital psychiatrist said he’d be ready to go back in a few days, but I got a call from Southern California Hospital at Culver City stating that ASC would not take him back.

During the first couple of weeks in the hospital he got better, but as the months drew on, too long in a hospital with not one bit of fresh air, decent therapeutic activity (it seemed only the security guard talked with my son) he got worse. He was then evaluated by DMH to go not to a Step Down, but to an IMD. That began the months’ long wait for another placement.

- FAILURE of ASC to provide effective therapy services to help the patient get to the source of the disrespect.
- FAILURE of ASC to use the incident as an excuse to evict the patient.
- FAILURE of the Levels of Care system to treat the chronically seriously mentally ill.
- EVIDENCE that inadequacies in the Levels of Care can contribute to the patient's stress, depression, feelings of isolation, disconnected from family, and suicidal ideation.

STORIES: ERCS -3

Once my son was sent to the ERCP, it appeared as though nearly two years of hospitalization and IMDs had been a waste of time as well as the county's money. Not required to attend the voluntary AOT meetings taking place at the ERCP, my son opted to walk around the neighborhood, entertaining himself by panhandling, smoking, and Dollar-Tree shopping.

It took months for the on-site therapist to cajole him into participating in some of the meetings. He did not appear to be getting anything out of the Enhanced Step Down experience and he wore the same clothes without washing them for months at a time. I don't believe ADL's were tracked at all.

I kept asking staff to assist him in laundry and they promised to help, but they did not. I was not even allowed to help him wash his clothes on site since non-residents are not allowed in the Laundry room, nor in the client's bedroom. I finally took the clothes home to wash.

It should also be noted that this ERCP has a reputation for being one of many ERCPs with open drug use and sales, within the facility and directly outside. I saw several residents smoking pot just outside the facility at times when I would pick my son up for an outing. It makes no sense to me why patients recently released from an IMD are put in an open Board and Care with others who are not participating in the Enhanced programs. Aside from the unsafe environment, common sense would dictate that newly released IMD patients could resent living with others not obligated to attend programs.

When my son was first admitted there, I had to track down the psychiatrist, therapist and case manager to fill them in on his history. With each new facility and treatment team, we have to start from scratch because the records do not seem to follow the patient. The case manager was friendly on the first call and then I never heard from her again in five months. My son was relapsing there and I feared where he would end up next.

When I informed staff that my son would be moving to another place, they made it impossible to obtain enough medication to see him through the transition easily. He left with only three days' worth of medication as they refused to provide a prescription for me to even get another month's prescription filled. This would have made the transition less stressful.

My son had to be rushed to the new psychiatrist the same day he moved, instead of being able to settle into his new home without the urgency to see a new psychiatrist immediately.

- ❖ FAILURE of Program Director to provide structure, support, guidance and programs that help residents learn life skills.
- ❖ FAILURE of Program to assist residents in ADL's.
- ❖ FAILURE of staff to be accessible, engage with the resident, and speak to family members.
- ❖ FAILURE of Program to address prevalent drug use and prevent substance use disorder.
- ❖ FAILURE of patient to be a therapeutic drug free and safe environment and in the company of others adhering to the program and activities.

STORIES: ERCS -4

My son was discharged from the IMD and was functioning optimally. He was transferred to an Enriched Board and Care. He was not allowed to leave the site for 30 days and became disillusioned because in spite of being released from a locked facility, he was not permitted to access the community even under the supervision of staff. Though he was functioning at a high level, he was in an environment with many others who were not. This was destabilizing. He complained of the drug use that was taking part in the facility. I spoke with personnel there and they acknowledged that drug use was happening, but that they were unable to contain it. The facility did not offer the tools needed to reintegrate back into the community and residents were not encouraged to be productive. My son left the facility on his own accord just shy of the 30 days and was not permitted back until he was evaluated by a doctor.

- FAILURE of facility to offer even minimal community access after entry from locked quarters.
- FAILURE of the facility to differentiate and address the needs of the residents they serve.
- FAILURE of the facility to proactively pursue a drug free zone for the protection of residents.
- FAILURE of the facility to provide meaningful reintegration tools that would encourage success.

STORIES: -TAY-1, FSP-2

After numerous Board & Care evictions, and right after getting discharged from a two month hospitalization, my son met with a TAY-FSP team. Only one Board and Care would take him, after so many evictions from others. My son caused property damage and sank to even lower levels, bartering for crystal meth, offered to him by another resident. He went AWOL and the FSP therapist concluded that NO Board and Care would be appropriate for his needs.

Instead of seeking out a higher level of care for him, they placed my son at a half-way house for ex-cons who were former gang members. These men had probation officers and were assisted in finding housing and work. My son had nothing to do all day except panhandle. This lasted 6 months. My son wanted to live somewhere else so the TAY-FSP team found him a Dual Diagnosis residence.

The other men at this house went off to Day programs, (covered by Medicare, or court ordered), but my son had nothing to do as there were no on-site therapeutic programs. He was evicted two months later because he called 911 when the House Manager would not give him an advance on his PNI money or cigarette allotment.

My son had not been violent or threatening to anyone, so he should have gotten a 30-day notice or at least a few weeks' notice, so that his FSP team could find him alternative housing. The owner was more concerned with how the sight of a patrol car would affect the neighbors. She gave my son only 10 minutes to gather his belongings and put him out on the street.

The FSP team had been meeting weekly with my son, but failed to be available when he needed them the most. The week he was evicted, the case manager went on vacation and the therapist told me directly that she was prioritizing a grieving girl whose father was killed.

My son was now forced into homelessness, without help from his therapist and case manager, and the Tay-FSP program did not send out a substitute team to cover for the absent case manager and therapist.

Weeks later when my son was on Skid Row, the therapist visited him there and he told her he was fine and did not need their services anymore. He was gravely ill, but FSP stuck to their legal guidelines to not provide services to anyone who is not 100% cooperative.

The FSP began the process of dropping my son as a client knowing fully well that he was in worse shape than ever but they made one last attempt to house him weeks later. Again, not in a HIGHER level of care, (which he desperately needed), but in a LOWER level of care.

They placed him in a SHARE Collaborative housing unit. These are homes for higher-functioning people who can take their own medication, go to school or have jobs, can clean and shop and cook for themselves. My son was incapable of doing these things.

He was asked to leave a week later when the other residents and house manager realized he was not in an appropriate environment. This led to a return to Skid Row and a medication over-dose.

- ❖ FAILURE of TAY-FSP program to do 5150s, to provide a higher level of care for a patient with a history of repeated evictions, resulting in more evictions and then homelessness.
- ❖ FAILURE of the FSP program to provide services for those who claim they do not need it, but FSP would know they need it if they are homeless and diagnosed with a serious mental illness.
- ❖ FAILURE of FSP management to ensure there will be an available member to assist a client during a time of crisis.
- ❖ FAILURE of FSP to protect client's legal right to a 30 day eviction notice, giving enough time for the FSP to find him new housing. Not doing so led to client's homelessness.

STORIES: IMD-1

My son who is of calm and quiet nature had no assaultive incidents during 1 ½ years at the IMD, but he refused to join groups. I asked if I could bring in an ABA therapist but that was denied. They also discouraged me from taking him out for any consultation stating this would trigger his elopement behavior.

In December 2019, during a smoke break he threw a lit cigarette at the face of a staff. The staff was not hurt but my son got agitated after being reprimanded and they sent him to the ER. The ER Psychiatrist reported that he arrived calm, was cooperative and there was no reason to keep him in the ER, so he requested the IMD to pick him up, but the Program Director stated that he could only return if medication was increased.

Later I asked again to the Program Director if my son could have ABA Therapy but it was declined. A month later my son suddenly punched a resident. Even though it was a quick impulse behavior, but he was totally calm shortly afterwards. He was sent to the ER immediately and I was informed he would not be allowed back.

He spent 3 weeks at the ER as there were no beds available in any hospital. After he was admitted at the Psychiatric unit he stayed 3 months in a hospital waiting for an IMD bed. During these 3 months he had no impulse behavior at all, therefore medication remained the same. He was finally admitted to another IMD and it took 6 months for the new medical team to approve him going back to the same supplements he was taking at the previous IMD.

How can my son become stable if he has to adapt to a new facility, a new staff, new residents and has not been able to receive family visits neither in person (due to Covid), neither by video, or by phone?

- FAILURE of allowing ABA therapy service inside IMD to improve the behavior of patients that don’t stabilize with medication alone.
- FAILURE of providing a Time-Out Room for patients to calm down instead of sending them to the overloaded ER.
- FAILURE of the IMD to inform Conservator about Eviction rules during admission.
- FAILURE of DMH to require a standard policy from providers on reasons to kick out a patient.
- FAILURE of the Mental Health System in not having more IMD’s so a patient who is stable does not need to be in a hospital for 3 months (often longer) just waiting for a vacancy.
- FAILURE of providing stability by keeping the patient with the same staff and doctors to build trust.
- FAILURE to provide computer access and phone access so family can visit during Covid times.

STORIES: IMD-2

When my son arrived at IMD, the medical staff were made aware of his pharmacogenetics test results identifying he is a poor metabolizer of most medications, has dose sensitivities and need for Folate supplements due to MHFR gene malfunction. I asked for my son to be on other supplements that support brain health prescribed by an MD specialist prior to entering the IMD.

The Director of Nursing refused to continue the supplements saying there were too many. As the Conservator I suggested putting all supplements inside a shake for breakfast, but she declined stating it could lead to other patients asking for the same.

The psychiatrist and Clinical Director allowed only Folate and Omega-3. He put my son on Tegretol even though he was not bi-polar. Tegretol requires regular blood work to check for toxicity and because it interferes with Vit D. The doctor did not place an order for regular blood check.

Month after month nurses stated that my son refused any blood draw. I had no other option than to schedule a visit with an outside doctor. The IMD denied transportation and staff to accompany us knowing that my son has elopement behavior.

The blood exam showed that my son had critically low levels of Vitamin D. The doctor refused to communicate with me, the Conservator, to discuss medication side effects. My son was put on a low dose of Vitamin D and a statin drug.

In the next blood exam the levels of Tegretol and triglycerides were quite high, Vit D still low. The doctor refused to lower the dose of Tegretol or Olanzapine.

I sent an email to the Administrator requesting help. I also copied the email to my court-appointed lawyer. The Administrator replied that the only thing she could do was to request the opinion of the in-house Pharmacist, but the Psychiatrist would have the final word.

The Pharmacist recommended reduction of Tegretol and Olanzapine and removal of the statin drug. The Psychiatrist only reduced Tegretol. It is important to note that when my son arrived at the IMD he had no cholesterol problem or memory problem. There was a point when my son did not recognize his father nor his brother during a visitation. After the Tegretol dosage was lowered, his memory seemed to have improved.

A week later, the social worker informed me that my son was good enough to move to a lower level IMD, contradicting what the staff said during the last Care Plan Meeting that he made no progress whatsoever.

- FAILURE of IMD to do blood draw to check blood levels of Tegretol and Vitamin D.
- FAILURE of the psychiatrist to lower dose of Tegretol following test results that showed toxicity, only agreeing to reduce only after Pharmacist's recommendation.
- FAILURE of Psychiatrist to respect Conservatorship and include Conservator in medication changes.
- FAILURE of IMD to allow as standard policy that residents receive supplements, which support their brain and general health.

STORIES: IMD-3

My son was a resident at the IMD for a year. He was regarded as being easy going and agreeable. One day he was grabbed from behind by a resident who was having an episode. In self-defense, my son was able to disengage from the individual, who got hurt in the process. I was informed by the nurse that he was not at fault but that the other individual had been hurt.

Upon leaving the facility, some months later after completion of the program and being stable, I asked for his medical records. My heart was broken at what I read. My son had been described as the perpetrator in the incident. His records also indicated that he had suicidal ideation which was untrue.

When I called to address the blatant lies that had been ascribed to him, I was met with an apology, but told that the written records could not be changed. There was no recourse to correct the falsehoods. I was horrified!

The mentally ill are stereotypically presented with a potential for violence. Documents written by those in authority that label them as violent, adversely affect their future prospects for ideal placement. I had no recourse to correct the falsehoods.

My son, like many other patients, paced the floor. The Psychiatrist there wanted to prescribe my son additional medication because he was pacing the floors. I explained that he would walk for miles to the nearest Guitar Center and was accustomed to being able to walk freely. I told the doctor that I did not want to add an additional med for a non-psychiatric issue.

The psychiatrist yelled at me and accused me of not wanting my son on any meds and not wanting to see my son well. I was shocked.

FAILURE of staff member to document a truthful and accurate account of an incident in the patient's record.

- FAILURE of staff to correct the reported inaccuracy, despite telling the mother her son was not at fault.
- FAILURE of staff in documenting an unsubstantiated symptom.
- FAILURE of the Psychiatrist to provide relevant treatment.
- FAILURE of the Psychiatrist to show professional behavior and respect for the Conservator.
- FAILURE of the Facility's Administrator to evaluate Psychiatrist's improper behavior toward a family member and improper treatment recommendation.

STORIES: IMD-4

My son resided at the IMD for exactly one year. Except for the Program Director, who was friendly and one time helpful, the rest of the staff appeared depressed, aloof or on automatic pilot. This was not a happy place and I have many grievances regarding “Quality of Life” issues lacking there. Some IMD’s are better than others, but they all fail miserably in areas which I believe support care and recovery for SMI patients.

During my son’s time there, he was not allowed to see the visiting psychologist because he did not have Medicare nor was he a Veteran. I had put in a request for him to get therapy because it seemed the most important service which could be offered to him in that environment. Instead, he was assigned to a weekly Psychology intern. She discussed with my son and also left me a voicemail message saying that my son should not be on Clozapine.

She described it as a “nasty” medication. Not being a medical doctor, I felt she was outside of her expertise and was also interfering with his ongoing psychiatric care. The IMD corrected her, but did not replace her with a more professional intern.

The Attending IMD psychiatrist was condescending on the phone when I arranged to speak with him to ask why my son was not even at a therapeutic level of Clozapine after being there for four months. He would only commit to discussing it further with my son the following month he would see him. The psychiatrist was taking at face value what my son reported to him, while my son told me and a peer coach something completely different. It was only because the Program Director intervened, that the psychiatrist started to increase the dosage.

I attended quarterly care meetings, where the Psychologist (who was not directly treating my son), a Nutritionist, an Activities Director, and DMH Discharge planners were in attendance. None of them had more than a couple minutes of data to share, and the meetings would have been over in ten minutes if I had not asked questions or made suggestions. They noted that my son lost a little weight on a low-fat diet, but the real reason he lost weight is because he did not have unlimited access to a junk food vending machine like the previous IMD and because he slept through the breakfast hour.

A month before his discharge, I was assured my son would not be leaving any time soon because he was still not participating in the number of weekly programs needed to qualify for discharge. And yet, the announcement of his discharge came suddenly a few weeks later. I was never told why he was suddenly being discharged if he was not participating in required number of programs as the reason previously given for not getting discharged.

The programs they offer are not comprehensive or effective if we measure them against the high relapse rate. Just as one example, the “Money Management” class was nothing more than telling the patient how much money they have each week to spend at the IMD canteen.

- FAILURE of IMD psychiatrist to arrange to speak with me in a timely manner.
- FAILURE of psychiatrist to consider medication increase until Program Director intervened.
- FAILURE of IMD to provide competent therapy by a licensed therapist.
- FAILURE to prevent a psych intern from saying inappropriate things to my son which could have resulted in non-compliance with his medication.
- FAILURE of IMD to provide licensed therapists to all patients, regardless of their insurance status.
- FAILURE of IMD to explain or justify an early discharge when he had not met the stated discharge criteria.

STORIES: IMD-5

The IMD staff knew that my son had a history of ulcerative colitis,but did nothing to monitor it. When I hospitalized my son for a medication trial, it was found that he had blood in his stool and diarrhea. He needed to have several polyps removed and a special surgery for one larger polyp. Now, I take him for colonoscopies every 6 months or so. I sent the instructions to the nursing station for one of my son's colonoscopy appointments. I drove from West LA to Long Beach to pick him up and take him to UCLA for the procedure. It turned out that the preparation had not been administered properly and so could not take place, and had to be rescheduled.

Due to poor dental hygiene, my son developed a lot of dental problems. The staff simply allowed him to "refuse" to see the dentist. In 2019, I decided to take him to a private dentist. I worked with my son and the dental office so that he would accept the treatment, which proved extensive. Although the dentist requested my son use an electric toothbrush (supplied by the family), the facility refused to allow it, stating no batteries allowed, but when told there weren't any and that it recharges electrically, they still denied the request. They allow mp3 players that need recharging so it doesn't make sense.

As a staff brought my son into the Visiting Room, I heard him say to my son, "My way or the highway."

While visiting another time, I heard an announcement over the loudspeaker announcing Movie Group, and the movie to be shown was a slasher movie.

- FAILURE of IMD staff to adhere to external doctor instructions for a colonoscopy prep or call conservator with any questions.
- FAILURE of IMD to teach good dental hygiene to prevent cavities and life-long healthy habits.
- FAILURE of staff to be respectful and not intimidate patients.
- FAILURE of IMD Program to protect patients from inappropriate movie content which could exacerbate symptoms.

OVERVIEW & CONCLUSION

1) UPDATE IMD'S ROLE AS THE FOUNDATION FOR STABILITY

By providing:

- A structured safe, low-stress environment with 24/7 care.
- The setting to evaluate the whole person's physical, mental and psychological health.
- The place to explore other treatments and participate in therapies that work in conjunction with medicine for improved outcomes.
- The place to safely reduce medication to discover the minimal dose that the patient remains stable, reducing side effects, and giving the patient more reasons to adhere to medication.
- The place to educate and engage the resident in habits that are conducive to better health and better relationships.
- The place to raise self-esteem and a feeling of usefulness by allowing patients to do small jobs within the facility, participate in art projects, or instruct other patients in an area where they have real skills, like music or computer.

2) UPDATE THE CONCEPT OF TREATMENT

Studies show that medication alone is insufficient in reducing the symptoms of those suffering from severe mental illness. The Severely Mentally Ill (SMI) require programs of treatment that address their environment, biochemistry, and psychosocial needs. This is well documented by hundreds of scientific studies.

The SMI are left behind and neglected by programs that are tailored to people who respond to medication and are higher-functioning.

Studies show that all chronic illnesses improve when inflammation is reduced.

Therefore:

- **Exercise is treatment** (and not optional as currently considered in all DMH contracted facilities).
- **Food is treatment** (and a healthy diet should be given to all residents and not only to diabetics and overweight patients).
- **Verbal and Non-Verbal Therapy is treatment** (art, music, play therapy are recommended for those with schizophrenia and thought disorders).
- **Environment is treatment** (home-like, low noise, access to outdoors, contact with nature).
- **ABA is treatment (**to teach appropriate behavior that leads to more independence and successful socialization. It is the #1 treatment for autism and urgently necessary for people with schizophrenia and SMI).
- **Skills Training Modules from the Rehabilitation Modules of the UCLA Psychiatric Rehabilitation Program** to train patients in particular areas of skills and social functioning that are congruent with his or her individual needs, such as Medication Management, Symptom Management, Recreation for Leisure, Basic Conversation Skills, Community Re-Entry, Workplace Fundamentals, Substance Abuse Management, Friendship & Intimacy.

- **Families should be allowed to provide treatments from outside providers that the facility does not.**

3) CHANGE THE METRICS REGARDING EVIDENCE OF TREATMENT ON PATIENTS PROGRESS REPORT FROM MEDICATION-CENTERED TO WHOLE PERSON CENTERED

The yearly report that IMD's are required to submit to DMH documenting medication increases as evidence of patient progress, is detrimental to the patients entrusted to their care. Failure to provide basic therapies and environments that foster real improvement along with medication, leaves only one standard of measurement; the progression of pharmaceuticals a resident consumes. This requirement has no doubt led to overmedicating of the residents, unnecessary changes to dosing and prescriptions, and even the falsifying of records and documentation.

4) LESS RUSH TO DISCHARGE

The current system “UCC – Hospital – IMD – Board & Care – Real World” pushes the SMI out into a lower level of care without them being ready, and it does not offer anything for them to feel good exactly where they are.

- **UCC’s rush** to push the SMI to Streets, Hospitals, Community clinics or Board and Cares as a poor alternative to therapeutic long-term care
- **Hospitals rush** to push the SMI to Families or IMD’s
- **IMD’s rush** to push the SMI to Step-Downs and Board and Cares
- **Board and Cares kick them out** back to Families, street or UCC

None of these places offer stability and the length of treatment the SMI need. Treatment as described on ***2)****. Therefore, it is imperative to invest in LONG TERM PERMANENT RESIDENTIAL TREATMENT HOMES or VILLAGES.*

5) MORE INVESTMENT IN LONG-TERM SAFE STRUCTURED STRESS-FREE TREATMENT

- Community Clinics do not provide enough support for the SMI. People with SMI need the **habit of frequent supervised repetition** to learn the basics self-care.
- People with SMI are not able to travel to a program. They need **treatment and training at the location** where they live.
- People with SMI have insurmountable obstacles that prevent them from maintaining stability upon discharge. They are faced with stigma and isolation. Being provided with a supported, safe, therapeutic, and accepting environment would dramatically improve their long term outcomes.

6) #1 PRIORITY: LONG TERM PERMANENT THERAPEUTIC HOMES AND VILLAGES

Los Angeles needs more IMD's with a quality 1-3 year program that really offers stability and once the program is completed, the person is then transferred to a **Long Term Permanent Therapeutic Home** inside a Village that offers the same support the IMD offers with a structured program: with exercise, leisure, community events, and work training, gardening, kitchen, carpentry, crafts, arts and non-stressful internships.

7) IMPROVE GUIDELINES IN CONTRACTS & ACCOUNTABILITY WITH PROVIDERS

DMH is failing to build better contracts with the Providers to demand services and quality that leads to better results.

- Quarterly surveys need to be collected from families that have loved ones inside **ALL Contracted Facilities,** in addition to allocating an Inspection Committee.
- DMH's Quality Improvement Assurance Committee currently collects only a broad survey from those who attend Outpatient Community Clinics.
- **No survey is collected from families with loved ones at IMD's, ERCP's, Board & Cares, UCC ; a majority of their SMI relatives do not provide feedback.**

Every business in America is under public scrutiny – but not the ones contracted by DMH. There is no competition. There are no public reviews. Providers' actions remain hidden. This non-accountability from DMH is allowing Providers to do outrageous things such as:

a) **Provide 1 sole psychiatrist for a large number of facilities** (Ex: Genesis.inc)

The Psychiatrist doesn't have time to observe the patient, read the history and study each case to prescribe the most appropriate medication and dosage.

b) **Lack of Psychological Services for All**

The Psychologist may appear at the admission meeting and never again. The Psychologist goes to work once a month, or once a week and may sit in a room waiting for a resident to go to them, which does not happen.

c) **A Philosophy of Scarcity aiming at Profits and not at Genuine Stability**

Providers accept more residents than they can optimally treat and it is questionable whether the number of staff is adequate or properly trained.

8) EDUCATE AND TRAIN DMH-CONTRACTED PROVIDERS/ STAFF ON DISTINGUISHING ANOSOGNOSIA FROM HUMAN RIGHTS CHOICES

- All DMH contracted Providers need to be further educated with courses and written materials (LEAP training), enabling them to better distinguish serious mental illness from behavioral problems.

- Contracted FSP providers (such as Telecare) need to initiate 5150's when needed, and not ignore evidence, such as suicidal ideation or signs of malnutrition.
- Staff must abandon the useless practice of asking a psychotic, un-medicated patient if "he believes he is well."
- Frontal-lobe dysfunction is not to be mistaken as "bad behavior."
- Inappropriate impulse behaviors should not be handled with IM injections, more medication or punishment. This method does not teach the patient coping skills or how to handle their own emotions, a vital tool for post IMD success. Instead, Staff needs to be trained and utilize ABA therapy to target specific behaviors. Use of positive reinforcement – not negative –and consistency and repetition of prompts are needed until residents learn new skills of impulse control, showering, taking medication, etc.

9) PUBLIC REVIEWS IN WEBSITE, FAMILY COLLABORATION AND OVERSIGHT

Families of the SMI are important contributors to the metrics developed by DMH. Families need to access the profile of each contracted facility by DMH and be able to post a review and give a star- qualification.

- Families of the SMI should be given quarterly surveys about the services.
- Families should be invited to participate in evaluation meetings.
- Families should be members of the Oversight and Accountability Committee.

Note: SALTs do not include IMD's in their agenda. Their focus is on Outpatient Services and Community Clinics. IMD families feel excluded and not heard. SALT does ZERO to address the reports of families. Therefore SALT does not have true "Community representation".

We know you are well aware of these problems. **There are funds to make these positive changes.** Families all over California, not just in Los Angeles, know that MHSOAC has been skirting their mandate to focus on the seriously mentally ill, which is what the taxpayers voted for and they need to re-prioritize funding for those with SMI first.

We don't need more bureaucracy, but we can be sure that more immediate and sustained mental illness crisis interventions would result in less homelessness, less incarceration, and less need for involuntary treatment. We would see better outcomes for all involved, mostly those with SMI. The system should embrace, honor, and better utilize the insight offered by family members instead of rejecting them.

RECOMMENDED RESOURCES

SCIENTIFIC STUDIES SUPPORTING OUR REPORT

Medication Dosage

Study Finds Less or No Medication After Psychosis Fosters Recovery | Psychiatric News (psychiatryonline.org)

Medication dosage & Cognition

https://www.hindawi.com/journals/schizort/2016/8213165/

Dose reduction of risperidone and olanzapine can improve cognitive function and negative symptoms in stable schizophrenic patients

https://journals.sagepub.com/doi/10.1177/0269881118756062

Schizophrenia in 2020: Trends in diagnosis and therapy - PubMed (nih.gov)

Pharmacogenetic and Neuroimaging Testing

IMPACT | Individualized Medicine: Pharmacogenetic Assessment & Clinical Treatment (camhx.ca)

https://www.apnews.com/57f88efc735141a6fa03c489738e2b8f

Treatment-Resistant Schizophrenia: Genetic and Neuroimaging Correlates - PubMed (nih.gov)

Prediction of response to drug therapy in psychiatric disorders - PubMed (nih.gov)

Nutrition and Diet

Diet Quality and Mental Health Amongst Acute Inpatient Psychiatric Patients - PubMed (nih.gov)

The link between food and mental health (apa.org)

*Frontiers | What Is the Role of Dietary Inflammation in Severe Mental Illness? A Review of Observational and Experimental Findings | Psychiatry (frontiersin.org)

Anti-Inflammatory Diets and Schizophrenia - PubMed (nih.gov)

An anti-inflammatory diet as a potential intervention for depressive disorders: A systematic review and meta-analysis - ScienceDirect

*Food and mood: how do diet and nutrition affect mental wellbeing? | The BMJ

Milestones in Human Microbiota Research (nature.com)

Western diet is associated with a smaller hippocampus: a longitudinal investigation (nih.gov)

Nutrients | Free Full-Text | Nordic Diet and Inflammation—A Review of Observational and Intervention Studies | HTML (mdpi.com)

Nutrients | Free Full-Text | Relationship between Mediterranean Dietary Polyphenol Intake and Obesity | HTML (mdpi.com)

An anti-inflammatory diet as a potential intervention for depressive disorders: A systematic review and meta-analysis - PubMed (nih.gov)

Gut Microbiome

Gut-Bacteria targeted Diet improves Mental Health

https://www.scientificwellness.com/blog-view/gut-bacteria-targeted-diet-improves-mental-health--683

https://pubmed.ncbi.nlm.nih.gov/30523432/

Gut microbiome shapes schizophrenia

http://blogs.discovermagazine.com/d-brief/2019/02/07/gut-bugs-may-shape-schizophrenia/#.XcCW9ZpKhzr

Use of Pre & Probiotic as auxiliary treatment in Schizophrenia

Frontiers | The Gut Microbiome and Schizophrenia: The Current State of the Field and Clinical Applications | Psychiatry (frontiersin.org)

https://www.frontiersin.org/articles/10.3389/fpsyt.2020.00156/full

Influence of gut microbiota dysbiosis on brain function: a s... : Porto Biomedical Journal (lww.com)

Nguyen TT, Kosciolek T, Eyler LT, Knight R, Jeste DV. Overview and systematic review of studies of microbiome in schizophrenia and bipolar disorder. J Psychiatr Res. 2018;99:50–61.

The microbiota–gut–brain axis (nature.com)

The Human Microbiota in Health and Disease - ScienceDirect

Effect of Probiotic Supplementation on Schizophrenia Symptoms and Association With Gastrointestinal Functioning: A Randomized, Placebo-Controlled Trial |Prim Care Companion (psychiatrist.com)

Nutraceuticals, Vit D, Omega 3, B12, Niacin, Folate, B6

148 studies on Vit D & Schizophrenia - Vitamin D and schizophrenia: 20 years on - PubMed (nih.gov)

Clinical and metabolic response to vitamin D plus probiotic in schizophrenia patients - PubMed (nih.gov)

OMEGA 3 - Efficacy of Polyunsaturated Fatty Acids (PUFAs) on Impulsive Behaviours and Aggressiveness in Psychiatric Disorders - PubMed (nih.gov)

The impact of omega-3 fatty acids, vitamins E and C supplementation on treatment outcome and side effects in schizophrenia patients treated with haloperidol: an open-label pilot study - PubMed (nih.gov)

Beneficial effects of omega-3 fatty acid supplementation in schizophrenia: possible mechanisms - PubMed (nih.gov)

The Effects of Probiotic and Selenium Co-supplementation on Clinical and Metabolic Scales in Chronic Schizophrenia: a Randomized, Double-blind, Placebo-Controlled Trial - PubMed (nih.gov)

Niacin-respondent subset of schizophrenia – a therapeutic review - PubMed (nih.gov)

Decreased Brain Levels of Vitamin B12 in Aging, Autism and Schizophrenia - PubMed (nih.gov)

Randomized multicenter investigation of folate plus vitamin B12 supplementation in schizophrenia - PubMed (nih.gov)

Adjunctive Nutraceuticals for Depression: A Systematic Review and Meta-Analyses | American Journal of Psychiatry (psychiatryonline.org)

Some People With Schizophrenia May Simply Have a Vitamin Deficiency (scitechdaily.com)

Vitamin B6 in treatment of tardive dyskinesia: a preliminary case series study - PubMed (nih.gov)

Diet and Psychosis: A Scoping Review - PubMed (nih.gov)

Nutritional supplements in psychotic disorders - PubMed (nih.gov)

Nutritional therapies for mental disorders - PubMed (nih.gov)

Computers help Schizophrenics improve Cognition

Targeted cognitive training improves auditory and verbal outcomes among treatment refractory schizophrenia patients mandated to residential care - ScienceDirect

Chronic, refractory schizophrenia patients benefit from targeted cognitive training (news-medical.net)

Computerized cognitive remediation improves verbal learning and processing speed in schizophrenia - PubMed (nih.gov)

https://www.sciencedirect.com/science/article/pii/S0920996418304705?utm_source=eNews+List&utm_campaign=8428f89beb-eNews-10-24-

Cognition Improvement helps Integration in Community

There is evidence that, beyond a certain dose of antipsychotic medication, the antipsychotic daily dose (ADD) may impair cognitive performance. Schizophrenic patients with better cognition are more likely to be in full- or part-time employment within two years of diagnosis [6]. These findings indicate the importance of cognition for the integration of patients into the community.

Pet therapy

Dogs might improve Schizophrenia by passing canine microbiome

https://www.psychologytoday.com/us/blog/canine-corner/202001/do-pet-dogs-affect-the-risk-schizophrenia-in-humans?amp

Lifestyle and Exercise

A meta-review of "lifestyle psychiatry": the role of exercise, smoking, diet and sleep in the prevention and treatment of mental disorders - PubMed (nih.gov)

Exercise and Schizophrenia – Intervention needed to increase Physical Activity Sedentary behavior = more negative symptoms

https://www.frontiersin.org/articles/10.3389/fpsyt.2019.00087/full

Aerobic exercise improves schizophrenia

3 Ways Aerobic Exercise Improves Schizophrenia Symptoms | Psychology Today

Aerobic Exercise Improves Cognitive Functioning in People With Schizophrenia: A Systematic Review and Meta-Analysis | Schizophrenia Bulletin | Oxford Academic (oup.com)

Enhancement of aerobic fitness improves social functioning in individuals with schizophrenia - PubMed (nih.gov)

EPA guidance on physical activity as a treatment for severe mental illness: a meta-review of the evidence and Position Statement from the European Psychiatric Association (EPA), supported by the International Organization of Physical Therapists in Mental Health (IOPTMH) - PubMed (nih.gov)

Exercise improves Cognition

http://europepmc.org/backend/ptpmcrender.fcgi?accid=PMC4314337&blobtype=pdf

Ping Pong is the best brain exercise

The Best Sport For Your Brain (gametablesonline.com)

Outdoor Nature

Public Health - Physiological impact of outdoor nature

Green perspectives for public health: a narrative review on the physiological effects of experiencing outdoor nature - PubMed (nih.gov)

Walking in Nature improves mental health

Stanford researchers find mental health prescription: Nature

The Self and Its Nature: A Psychopathological Perspective on the Risk-Reducing Effects of Environmental Green Space for Psychosis - PubMed (nih.gov)

Forest Bathing against Stress, Depression

The physiological effects of Shinrin-yoku (taking in the forest atmosphere or forest bathing): evidence from field experiments in 24 forests across Japan - PubMed (nih.gov)

Music Therapy

Music Therapy as Treatment of Negative Symptoms for Adult Patients Diagnosed with Schizophrenia-Study Protocol for a Randomized, Controlled and Blinded Study - PubMed (nih.gov)

18 studies with 1200 participants - Music therapy for people with schizophrenia and schizophrenia-like disorders - PubMed (nih.gov)

The Effect of Music on Auditory Hallucination and Quality of Life in Schizophrenic Patients: A Randomised Controlled Trial - PubMed (nih.gov)

BOOKS AND FILMS

Insane Consequences: How the Mental Health Care System Fails the Mentally Ill

By DJ Jaffe

**This policy book outlines what has historically not worked to help the seriously mentally ill in the U.S. and what needs to change. There is a special emphasis on those wither SMI who do not respond to treatment.

Breakdown: A Clinician’s Experience in a Broken System of Emergency Psychiatry by Lynn Nanos,

L.I.C.S.W.

**This book documents an emergency psychiatric nurse’s experiences in getting mentally ill people hospitalized, only to see them discharged before they are stable and without an appropriate follow-up treatment plan.

Clozapine: A Meaningful Recovery from Schizophrenia by Robert S. Laitman, M.D. and others

**This book narrates how a young man with schizophrenia got a high level of care with involved parents and a psychiatrist who agreed that he take clozapine as a first line of defense, instead of making it the last medication to try.

Shattered Families, Produced by Dr. Stephen Seager.

**This is a documentary on YouTube which highlights what is wrong with the mental health care system, how the major mental health care agencies are misguided, and what can change to improve the whole system.

***Tomorrow Was Yesterday**: Explosive First-Person Indictments of the US Mental Health System-Mothers Across the Nation Tell It Like It Is* By Dede Ranahan with 64 Co-Authors

WEBSITES

The Treatment Advocacy Center is a national organization, founded by Dr. E. Fuller Torrey, which continually works to change legislation and advocate on behalf of those with serious mental illness.

www.TreatmentAdvocacy.org

The late DJ Jaffe has an information-dense website, which includes legislation and facts relative to California.

www.MentalIllnessPolicy.org

Valuable information from nationally recognized author and mental illness advocate Pete Earley.

peteearley.com