APRIL - MAY 2011

NEWSLETTER

ALLIANCE ON MENTAL ILLNESS

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21st Century Inpatient Psychiatric Care: The Need For Reform

(Editor's note: The following is from an Open Forum recently published by *Psychiatric Services,* a journal of the American Psychiatric Association.) By Ira D. Glick, M.D.
Steven S. Sharfstein, M.D.
Harold I. Schwartz, M.D.

Inpatient psychiatric care in the 21st century is defined by ultrashort lengths of stay.

In the last two decades of the 20th century, length of stay for psychiatric inpatient care decreased from months to days.

The sole focus of psychiatric inpatient treatment has become safety and crisis stabilization.

This Open Forum addresses the need to reconsider the current model of ultrashort inpatient hospitalization in order to maximize positive outcomes and emphasize appropriate transition to the community and less intensive levels of care.

The patient population on which we focus includes those who most clinicians would agree require a 24-hour inpatient stay, not those who can be treated in partial hospitalization or in residential or other outpatient settings.

We recognize there is a body of literature on alternatives to the hospital, but for most patients in an acute psychiatric crisis, hospital stays are the only option. As this nation implements health care reform we cannot fail to address the necessary changes in the mental health care system, including hospital care, that will make treatment more effective, efficient and recovery oriented.

The President's New Freedom Commission report, the Surgeon General's report that preceded it and a variety of other public policy directives have steered psychiatric services in the United States clearly and emphatically toward the goals of the recovery movement.

These goals require that psychiatric services address the patient's aspirations for a life as a member of the community and focus on the patient's occupational, vocational, social and spiritual needs in order to further that aim.

It is not paradoxical to note that although a diminished role for institutional care is consistent with recovery, ultrashort hospitalizations may diminish opportunities for a sustained recovery.

The Effectiveness Of Inpatient Care

Our evidence base would be vastly enhanced by controlled studies of inpatient procedures, length of stay and outcomes.

A modest literature of controlled studies of best treatment for particular disorders exists in this regard from the 1970s and 1980s Most of that literature suggested that shorter rather than longer stays were more effective for most psychiatric disorders (however, the shorter stays in these studies would qualify qualify as longer stays today.)

The only study with findings that differed was by Glick and Hargreaves in the 1970s that compared short hospital stays (21-28 days) with long hospital Continued on Page 3

Our Upcoming Speakers

Third Wednesdays, 6:45p.m.
14545 Sherman Circle, Van Nuys
Questions Answered, Refreshments

April 20: Dr. David Miklowitz, Director of UCLA's Child and Adolescent Mental Health Program.

May 18: Success Recovery Panel consisting of members from the Van Nuys Victory Wellness Center will give their mental health histories and discuss their road to, and journeys on, the recovery road and the highway to success.

June 15: Dr. Maria Longhitano, is staff psychiatrist at Hillview Mental Health Center and former staff psychiatrist at USC, CSUN student counseling centers, a consultation and liaison psychiatrist at Olive View Hospital. She is a graduate of the University of Catania, Italy.

NAMI San Fernando Valley April — May 2011 Calendar

Van Nuys - April
14545 Sherman Circle

April 6, Wednesday, 7 p.m. Special Care and Share Group for spouses, brothers, sisters, adult children of persons with mental illness.

April 13 & 27 Wednesday, 7 p.m. Care and Share Support Group for families and friends of persons with mental illness.

April 20, Wednesday 7 p.m. Welcome speaker Dr. David Miklowitz, director of UCLA's child and adolescent mental health programs.

Santa Clarita - April
23501 Cinema Drive Room 200

April 5 & 19 Tuesday, 6:30 p.m. Special Care and Share Group for families and friends of persons with mental illness.

Reseda - April
18300 Roscoe Northridge Hospital Carole Pump Behavioral Health Services Entrance first floor. Park in lot on Etawanda across from hospital.

April 7 & 21 Thursday, 7 p.m. Care and Share Support Group for families and friends of persons with mental illness.

April 19 Tuesday, 7 p.m. Special Care and Share Group for spouses, brothers, sisters, adult children of persons with mental illness.

West Hills - April
22450 Sherman Way (west of Shoup) West Valley Christian School

April 11 & 25, Monday, 7 p.m. Care and Share Support Group for families and friends of persons with mental illness.

Van Nuys - May
14545 Sherman Circle

May 4, Wednesday, 7 p.m. Special Care and Share Group for spouses, brothers, sisters, adult children of persons with mental illness.

May 11 & 25 Wednesday, 7 p.m. Care and Share Support Group for families and friends of persons with mental illness.

May 18 A panel of consumers from Victory Wellness Center will share their stories on the roads to recovery and on to the highways of success.

Santa Clarita - May
23501 Cinema Drive Room 200

May 3 & 17 Tuesday, 6:30 p.m. Special Care and Share Group for families and friends of persons with mental illness.

Reseda - May
18300 Roscoe Northridge Hospital Carole Pump Behavioral Health Services Entrance first floor. Park in lot on Etawanda across from hospital.

May 5 & 19 Thursday, 7 p.m. Care and Share Support Group for families and friends of persons with mental illness.

May 17 Tuesday, 7 p.m. Special Care and Share Group for spouses, brothers, sisters, adult children of persons with mental illness.

West Hills - May
22450 Sherman Way (west of Shoup) West Valley Christian School

May 9 & 23 Monday, 7 p.m. Care and Share Support Group for families and friends of persons with mental illness.

Improved Prevention, Reduction Of Obesity Among Persons With Serious Mental Illness Called For By State Mental Health Directors

Persons with serious mental illness served by the public mental health system die 25 years earlier than the general population, primarily from chronic and treatable medical illnesses.

Diseases such as metabolic syndrome, heart disease, hypertension and diabetes are major contributors to the higher rates of death of persons with serious mental illness and are strongly linked to obesity.

As a result of these findings and the growing concern regarding psychiatric medications as a cause of obesity, the Medical Directors Council of the National Association of State Mental Health Program Directors recently released a policy paper, *Obesity Reduction and Prevention Strategies for Individuals With Serious Mental Illness.*

NASMHPD represents state executives responsible for the $29.5 billion public mental health service delivery system serving 6.1 million people annually in all 50 states, four U.S. territories, and the District of Columbia.

NASMHPD's Medical Director Council's membership comprises state medical directors of state mental health authorities from across the country.

The council's policy paper is a review of the prevalence, impacts, prevention and treatment of obesity for persons with serious mental illness and a follow-up to its 2006 report, *Morbidity and Mortality in People With Serious Mental Illness.*

Obesity is a public health crisis in America. Approximately 65% of adults in the United States are either overweight or obese. Persons with serious mental illness are two to three times as likely to be obese as the general population, with reports that over three-quarters of women with schizophrenia are over weight or obese.

In the process of researching and developing the report, the Medical Directors Council became convinced that psychiatrists are doing far too little to prevent and reduce obesity for either the physical health or the mental health recovery of patients they serve.

Most psychiatric clinics and community mental health centers do not offer obesity prevention and intervention strategies to their patients even though these patients are at high risk for obesity and many of the psychotropic medications prescribed for treatment of their mental illness cause weight gain.

There is a prevailing assumption that weight loss interventions are not effective for persons with serious mental illness. The report debunks this assumption.

Weight loss treatment programs are as effective for persons with mental illness as they are for the general population. Half of the persons with serious mental illness in weight loss programs lose clinically significant amounts of weight.

Medications specifically for the treatment of obesity can result in weight reduction of 10%. Yet most psychiatrists are unfamiliar with these medications and uncomfortable with prescribing them.

Psychiatrists could benefit from additional training on prescribing medications, such as phentermine and sibutramine.

Because behavioral and medication treatments for obesity rarely yield more than a 10% to 15% weight reduction, bariatric surgery is the treatment of choice for patients with morbid obesity.

These individuals likely face significant medical dangers as a result of their weight.

Psychiatrists in the public mental health system must make sure that their patients with morbid obesity have access to this potentially life-saving intervention. These psychiatrists should also assist their patients in making informed choices about the risks and benefits of bariatric surgery which is covered by Medicare, Medicaid and third party insurers.

Mental health professionals need to be educated on the importance of weight monitoring and weight management among people with serious mental illness. Common misconceptions and stereotypes that persons with serious mental illness are not able or willing to participate in weight reduction programs need to be recognized and confronted.

Providers need to be encouraged to treat both the physical health and the mental health of their patients. This means coordinating care between primary and mental health professionals with good communication and collaboration.

—Psychiatric Services

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NAMI SFV NEWSLETTER

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Tributes

NAMI

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A Tribute

To: June Shelby
From: Barbara Gauthier

NAMIWALKS Team Captains, Company Contacts Needed

NAMI SFV Fundraising Committee Chairwoman Beth Arnold needs additional team captains and members help to solicit sponsorship dollars from companies and contributors for the seventh annual NAMIWALKS for the Mind of American on October 1, 2011 in Santa Monica.

Last year NAMI SFV members contributed and raised $18,000 for our affiliate. This year's goal is $25,000. E-mail Beth at: beth@namisfv.org

Sole Focus Of Psychiatric Inpatient Treatment Has Become Short Stay, Safety, Crisis Stabilization

stays (90-120 days). Continued from Page 1
Patients with schizophrenia who had good functioning before hospitalization and who received the extra days of hospital treatment showed better outcomes at six and 18-month followups. This outcome resulted from a combination of postdischarge psychotherapy and medication compliance.

There are no data from controlled studies on outcomes of ultrashort-stay hospitalizations to guide clinicians or public policy. Of course, in the absence of data, less expensive programs are preferred by payees.

Notably, a recent review of the literature from Europe made the point that "there has been some unsettling evidence to suggest that shortening hospital stays may not be a general panacea."

In the current prevalent hospitalization model the average length of stay is five or six days.

This model requires that the problem occasioning admission be formulated within 24 hours whether admission occurs on a weekday or weekend.

Moving the patient through this hospital assembly line requires more than diagnostic assessment be completed within 24 hours but no more than 48 hours.

However, admission requirements that focus on dangerousness as the only criterion for medical necessity of an inpatient stay ignore the realities of mental illness.

Many admitted patients are taking multiple medications or illicit drugs and have comorbid medical illnesses.

Before completing the diagnostic process, psychiatric residents of a generation ago were taught the value of observing patients when they are off all drugs and medications. This is no longer possible.

It is worth noting that patients admitted late in the week (Friday or Saturday) may spend the entire critical period of assessment, diagnostic formulation, treatment planning

and treatment initiation in the care of covering physicians, who are often "moonlighters."

Ultrashort stays have severely eroded the interpersonal connectedness of staff, patients and families. At the same time, the emphasis vironment of many hospital psychiatric units, lending them a prison-like atmosphere. The overall effect is a dehumanized physical, psychological and social environment for patients when they are in most acute need. We believe that ultrashort inpatient hospitalization may do more harm than good.

Goals, Treatment Modality

Given the lack of studies of outcomes of ultrashort stays, we propose a decision model based on a careful phenomenologic and psychosocial diagnosis of the problem using DSM-IV, as well as an evaluation of patient and family strengths, available resources, achievable goals and interventions that cannot be safely undertaken in an outpatient setting.

In short, we recognize the need to individualize treatment depending on the patient's treatment depending on the patient's condition, his or her previous experience with treatment and the family and other resources available to support the treatment.

Therefore, it is necessary to recognize that rational treatment for psychiatric patients differs from that for medical or surgical patients. A focus on insuring only safety leads to an overemphasis on the biological aspects of care (generally psychopharmacologic) to reduce aggressive behavior and leaves for too little time to address the psychosocial aspects critical to understanding and intervening in the larger context and changing the course of illness.

A frequent result is rudimentary discharge plans that do not account for many predisposing issues and all too often lead to recurrence and readmission. Factors that commonly compound the need for acute treatment—for example, cognitive impairment, comorbid disorders, denial of illness and severe functional impairment—often go unaddressed or, worse, unrecognized.

Issues such as the need for stable housing, which is critical to continued remission of illness, can barely be discussed.

If we are going to give anything more than lip service to recovery, we need to rethink the current model.

We cannot rethink the model without considering the goals of recovery. Even rudimentary knowledge of the recovery movement suggests that the ultrashort-stay paternalistic and not patient centered. With the focus on safety, most patients are admitted involuntarily.

The rapidity with which treatment decisions must be made makes a mockery of patient participation in multidisciplinary treatment planning and psychoeducation.

Finally, the larger goals of recovery that involve the social-interpersonal, residential, occupational, vocational and spiritual contexts of patients' lives and illnesses can rarely be adequately addressed.

Three Phases Of The Inpatient Stay

We suggest a model of care based on established principles that have been lost in the length-of-stay crush. Our model proceeds in three stages: assessment, implementation and resolution of hospitalization.

The assessment phase is what needs to be done before or as soon as the patient arrives in the inpatient unit from the emergency department. As much as possible should be accomplished before the patient arrives, which often requires an intake clinician.

The implementation phase (that is, the period of active medication trial or of detoxificaiton) varies in length according to the specifics of the case and the resolution phase is also variable depending on goals.

The resolution phase focuses on solidification of gains made of the implementation phase and on ensuring an effective transition to the community and the next level of care, including discharge planning tasks that should begin during the assessment phase.

Assessment Phase

Ideally, a substantial portion of the assessment phase should occur before actual admission. We readily acknowledge that the reality of unknown patients in pressured emergency departments makes this an ambitious goal. Certainly for patients who are known to the hospital system, financial screening, critical history gathering and preliminary diagnostic assessment should be done before admission.

The assessment phase is a critical time to observe, gather information and formulate a plan before active treatment (except for safety measures, which need immediate implementation). Effective gathering and communication of information are emphasized. Old and current medical records (electronic preferred) must be obtained and contact should be made with treatment providers and the patient's significant others.

The model requires Continued on Page 4

Sole Focus Of Psychiatric Inpatient Treatment Has Become Short Stay, Safety, Crisis Stabilization

relying on the intake Continued from Page 3 clinician for more than the usual admission decision and provision of a rudimentary history.

The intake clinician may have access to sources that are not available to inpatient staff (for example, a detaining police officer) and must capitalize on this unique opportunity to gather and transmit critical information.

Poor handoff from the emergency department to the inpatient unit is a common source of wasted time and energy. The intake clinician must accurately convey the history, diagnostic assessment and reason for admission.

In other areas of medicine or surgery, the admission diagnosis may directly set the course of the treatment plan.

Treatment algorithms for acute appendicitis or myocardial infraction clarify the next steps of care for providers and payers alike. However, few such algorithms are in place for psychiatric care.

In their absence, goals of the assessment phase include a thorough history, a plan for proposed treatments, a sense of achievable goals and likely prognosis.

Implementation Phase

The implementation phase is the core of the actual inpatient stay and should accomplish more than merely ensuring safety during a crisis.

The crucial objective is to further define the issue or issues that led to hospitalization and implement interventions that change the illness trajectory.

For example, if a patient with major depressive disorder has relapsed and his or her condition is resistant to other treatments, the task may be to implement electroconvulsive therapy. If a young adult with schizophrenia has stopped taking medication and is acutely psychotic, the primary task may be psychoeducation for patient and family and resuming medications, with consideration on intramuscular injections.

The objective which is lost in the ultrashort model, is to treat the current episode but, equally important, is to put measures in place that will prevent subsequent episodes.

Several factors call for a longer length of stay in this model.

They include a return to more thorough diagnostic assessments, which require complete history gathering and periods of patient observation. The time allowed for trials of medication should comport with what we know about how psychotropic agents actually work.

Assessments of precipitating factors and interventions to address them, family interventions, psychoeducation and the establishment of therapeutic alliance must all be given their due and are critical factors in the patient's future adherence to treatment.

Resolution Phase

The resolution phase is absolutely critical in this redefined model of psychiatric hospitalization in order to consolidate the gains made during the implementation phase and ensure effective continuing treatment in day programs, intensive outpatient alternatives and residential and community settings.

Here again, the special needs of psychiatric patients with cognitive and functional impairments, comorbidities and denial of illness may require interventions that demand more time in this phase.

Patients (and family members) are adjusting to the changes produced by the interventions made during the implementation phase and they need ongoing support to understand, tolerate and adhere to them.

Issues of financial support and posthospitalization living circumstances must be resolved in order to establish effective coordination and continuity in follow-up care.

A mere generation ago, it was considered critical to make an effort handoff to the next level of care. Inpatients were routinely sent on passes to meet their caregivers and to be introduced to follow-up programs.

We stopped doing this not because we had evidence to demonstrate that it was an ineffective practice but because insurers would no longer pay for the added time in the hospital.

Better transitions are more consistent with the goals of recovery and are ultimately more cost effective.

Principles Guiding Criteria For Length-Of-Stay Decisions

The inpatient hospitalization provides a unique opportunity to marshal resources that otherwise would not be available for the treatment of an episode of mental illness.

Precise criteria for determining an appropriate length of stay are inexact at best, although a number of core principles may be applied.

An overarching principle is the length of stay should be driven by clinical need and determined by clinicians involved in the patient's care.

Clinical need should be measured against the ongoing effectiveness of the inpatient intervention to ensure safety, produce stability (and remission when possible), and set the stage for successful reintegration to life outside the hospital (reducing the likelihood of readmission).

Focusing primarily on safety issues requires a parsing of clinical judgments that is too narrow and specific for the ambiguous clinical realities we so often face. As a result, risk may be actually increased while the utility of hospitalization to fully address the episode of illness and to prevent recurrence is diminished.

The following specific principles are notable equally for being both obvious and frequently ignored.

Their practice may increase length of stay. They may be thought of as criteria for determining length of stay in that discharge should not occur until each has been accomplished.

- Practice established principles of psychopharmacology. These include withdrawal of ineffective or toxic medications over appropriate periods, observation periods after withdrawl, reintroduction or addition of one medication at a time and appropriate periods for medication trials.
- Treat comorbid factors (for example, substance abuse and general medical problems) that contribute to the need for hospitapalization and that may increase the risk of recurrence.
- Address the intrapsychic life of the patient, along with family issues and other social and environmental factors. Such factors must be considered in order to understand precipitating factors and response to treatment and to ensure successful disposition planning.
- Adhere to recovery principles especially the role of the patient in treatment planning. The patient's meaningful participation in treatment planning implements the patient's right to choose. This may increase length of stay but may also increase adherence and the likelihood of a positive outcome.
- Provide psychoeducation and build a therapeutic alliance.

Continued on Page 5

Sole Focus Of Psychiatric Inpatient Treatment Has Become Short Stay, Safety, Crisis Stabilization

Continued from Page 4

In addition to the principles stated on the previous page, our model has a number of staffing requirements. We suggest the following:

- An experienced preadmission or intake specialist at the "inpatient door" who understands the dynamics of the community, the emergency room and the inpatient unit and who can work easily with physicians and other clinicians, parents, families and significant others to facilitate the patient's entry into the care system. Such a person must be skilled at negotiating the precertification systems established by payers, which so often seem like roadblocks to care.

- A transition to "psychiatric hospitalists," psychiatrists and advanced-practice registered nurses who are very experienced in treating severe mental illness in inpatient settings and are very competent in psychophamacology. The time is short and the complexity high.

- Specialized nurses, analogous to operating room nurses, who are experienced in acute care, safety and the procedures necessary for achieving our descried objectives.

- The "treatment manager," who can be a social worker (and most often is), a psychologist, or even nurse (not working within the usual nursing hierarchy). The person in this role conducts assessments, individual and family work and dispositions (the traditional social work role). In other words, this is the patient's primary therapist-clinician, who works collaboratively with the physician. For some hospitals this may be a new role.

- A part-time general internist to address the high level of general medical comorbidity inherent in many psychiatric illnesses.

- The family member, significant other, or outpatient caseworker-clinician who provides the glue to move from pre- to postadmission stages should also be considered a member of the team. The focus is involving and educating families about the illness—its recognition, its treatment and access to services.

Our model calls for consideration of the culture of inpatient units and the treatment methods employed.

We have lost our focus on the therapeutic power of the milieu. Many training programs are available for staff in the culture of recovery and related themes, such as trauma-informed care.

Programs to reduce reliance on seclusion and restraint generally enhance the therapeutic milieu, increase safety, diminish regression and facilitate the patient's progress.

Why The Hospital Is Necessary For Treatment

Many would argue that outpatient care can accomplish the above goals without the need for a hospital if the patient is not at risk.

Two categories of reasons argue against this assertion. The first set of indications for hospitalization is similar to those our colleagues in the medical and surgical specialties follow.

Medical and surgical patients are hospitalized (arguably for many reasons) when their conditions are life threatening, require procedures that can be done only in a hospital, require a large team that cannot be assembled in an outpatient setting, require extensive or in-depth diagnostic procedures, or require long periods of observation while the patient is receiving treatment to try stepwise procedures or alternative treatments.

The second set of reasons is more specific to psychiatry because psychiatric patients have problems that patients treated by other specialties do not have and that make outpatient treatment difficult, if not impossible.

First, psychiatric patients usually have cognitive problems and psychotic symptoms that prevent them from being "full partners on the treatment team." These include denial of illness and fearfulness about seeking treatment.

Second, these patients have a high rate of nonadherence in outpatient settings to complicated psychosocial and psychopharmacological treatment regimens.

Third, psychiatric patients often lack family or significant others to facilitate treatment and lack resources, such as transportation, to access treatment.

And finally, the stigma associated with psychiatric treatment works against the patient's getting adequate help in an outpatient setting as well as in continuing treatment once he or she is hospitalized.

For all of these reasons, voluntary or involuntary hospitalizaitons may be indicated and may require longer stays (longer than ultrashort stays) to achieve stabilization—that is, to ensure that the patient can survive outside the hospital and to arrange long-term (posthospital) care in order to change the downward trajectory.

The argument against this model is that if it can be done just as well for less money outside of a high-tech hospital—that is, in a new version of the "hospital of the past," which encompasses specifically low-tech observation followed by social interaction and time spent in a truly therapeutic milieu outside of the hospital. Of course, we don't have such a model or such a setting at this point.

Conclusions

Our model is not new or revolutionary, nor is it evidence based in the true meaning of the term. However, it is our effort to address a problem that is vexing and enduring with an approach that is provocatively looking to the past for a way toward the future.

The evidence base for various approaches to inpatient psychiatric care is sadly lacking. We would be greatly helped by moving beyond patient satisfaction surveys to objective measures of outcomes.

But in the absence of an evidence base for ultrashort hospitalization, we have an ethical obligation to promote what we consider to be the best practice.

Health system reform means just that—reform of the system itself. In the inpatient psychiatric setting, it should start with providing treatment that is nuanced and, in the spirit of recovery, intended to make an effective impact (beyond the assurance of safety) on the life course of the patience with severe psychiatric illness.

Need NAMI SFV Members To Provide Information At Upcoming April Health Fairs

By Julia Robinson Shimizu
NAMI SFV Vice President

As an all volunteer community organization, we can help our community by providing information on NAMI SFV and the availability of local mental health services.

Members are needed to assist providing information at local health fairs. It will only take a few hours and ensures families in need of comfort, resources and support to learn about all the free services NAMI SFV provides.

If you are able to help at any of the upcoming community health fairs, call 818 949 6747 and let our Volunteer Chairwoman Sari Rynew know you would like to help.

Date, Times and Locations are:

10 April 6 a.m.-11:30 a.m. Woodley Park
10 April 11 a.m.- 4 p.m. Westfield Mall, 6600 Topanga Canyon Blvd.
23 April 10 a.m. - 1 p.m. Shadow Ranch Recreation Center 22633 Vanowen Street

NAMI San Fernando Valley Resource Directory

Inclusion in this directory does not necessarily imply endorsement by NAMI San Fernando Valley, its officers or members.

Adult Protective Services
- Van Nuys Regional Services 818.901.3981

AIDS Concerns
- AIDS Project LA 800.922.2437

Area NAMI Affiliates
- Antelope Valley 661.945.8018
- Glendale 310.663. 3844
- Los Angeles 310.478.8761
- Other Los Angeles County areas 213.632.0782
- San Gabriel Valley 626.577.6697
- San Fernando Valley 818.994.6747
- Santa Clarita Valley Family Group (Zee Dankworth 661.360.8002 or 818.371.9381)
- Spanish Language 818.383.3716
- Simi Valley 805.526.0766
- Thousand Oaks 805.495.5031
- Ventura County 805.641.2426
- NAMIs Nationwide 800.950.6264
- NAMI California 916.587.0163 namicalifornia.org 1010 Hurley Way #195 Sacramento 95825
- National Alliance on Mental Illness 703.524.7600 Colonial Place Three, 2107 Wilson Blvd. #300 Arlington, VA 22201 www.nami.org
- State Hospital NAMIs: Metropolitan State Hospital NAMI 323.721.5114 Meets Second Saturday of the Month Patton State Hospital NAMI 902.425.7000 Meets Third Saturday of the Month 11:45 a.m.-1:15 p.m.

Benefits
- Help with SSI/SSDI Problems: Mental Health Advocacy Services 213.389.2077 Ask for Sherrill Martin.
- MediCal Helpline (toll free) 877.597.4777
- Medicare Fraud Hotline 800.447.8477
- Social Security Application for SSI/SSDI Questions or address of closest office 800.772.1213
- Welfare (Dept.Public Social Services) All-Area Helpline 877.481.1044

Borderline Personality Disorder
- National Education Alliance for BPD 914.385.901 www.borderlinepersonalityorder.com
- BPD Resource Center 888.694.2273 www.bpdresourcecenter.org

Case Management
- Call your area Mental Health Center as shown on the last page of this newsletter.
- PLAN Private case management. 888.574.1258

Charities for Mental Illness
- NAMI SFV Tribute Cards 994.6747 Press #. Ask for Marion Kuzman. Leave name and number.
- NARSAD, the National Mental Health Research Association, 60 Cutter Mill Road, Great Neck, NY 11021
- NARSAD Greeting Card Catalog 800.607.2599

Children and Adolescents
(Up To Age 18)
- ADD/ADHD 800.233.4050 www.chadd.org
- Autism Society of America 800.328.8476
- Aviva (Adolescent Girls) Assessment/Shelter 780.1005
- Psychotherapy (To Age 21) Center for Hope and Health, Inc., MediCal 704.8541
- Child and Family Program San Fernando Mental Health Center 832.2400
- Child Protection 24/7 Hot Line 800.540.4000
- Child/Adolescent Bipolar Foundation 847.256.8525
- DMH Valley Coordinated Children's Services: Crisis Intervention/Assessment; Telephone Triage; Psychiatric Hospitalization (located in Reseda) 708.4500
- Housing: Families with Children: Beyond Shelter 213.252.0772
- Housing: Youths 18 to 21 Hillview Mental Health Center, Pacoima 896.1161 extension 274 or 275
- Healthy Families MediCal Information Line (English) 888.747.1222 (Spanish) 888.777.1212
- Learning Disabilities Association 888.300.6710
- Low Cost/Free Child Health Insurance 877.543.7669
- National Center for Learning Disabilities 888.575.7373
- National Center Parents With Disabilities 800.644.2666
- New Horizons, Glendale 549.2250
- Santa Clarita Child and Family Guidance Center 661.259.9439
- San Fernando Valley Child and Family Guidance Center 993.9511
- San Fernando Valley Community Mental Health Center, Inc. Youth (18 to 20) Day Treatment and Transitional Housing Program, MediCal 909.4990
- Special Education Information Line 800.434.2465
- Teen Line 310.855.HOPE 6 p.m. to 10 p.m.

Client Groups
- Friendship "Warm" Chat Line 888.448.777
- Gay/Lesbian Project Return Club "Fruits & Nuts" Hollywood Gay/Lesbian Center 213.651.6209
- Los Angeles County Department of Mental Health Client Coalition 213.637.2371
- "Project Return: The Next Step Up" (sponsored by the Mental Health Association, Los Angeles) meets at 6 p.m., Wednesdays at Center for Family Living 14545 Sherman Circle, Van Nuys. 780.8279 Preteens Contact Annette Merer 321.2108

Clinics
- See last page of this newsletter for list of public mental health centers and areas served.
- Asian Pacific Clinic and Treatment Center, Van Nuys Phone 267.1100

Clubhouses for Clients
- Victory Wellness Center 14411 Vanowen (1/2 block east of Van Nuys Blvd.) Van Nuys, 91405 Phone 989.7475
- Arden House, Glendale 244.7257
- Daniel's Place, Santa Monica. Free Help and Referrals for ages 18 to 30 Experiencing First Break. Family Included. 310.392.5855

Conservatorship
- Conservatorship Booklet NAMI SFV Library
- Katharine Van Dyke, Family Liaison 213.974.0509
- Public Guardian Office 213.974.0515 (After Hours Emergency 213.974.1234)
- Superior Court Dept. 95 (Mental Illness Court) Richard C. Luckham 323.226.2913

Crisis/Emergency
- See Below and Crisis Numbers On Back Page
- LA County Department of Mental Health: Multilingual Crisis Line 800.854.7771 Emergency Outreach Bureau 213.738.3433
- LAPD/LA County Department of Mental Health Assists Officers 213.485.4188
- Private Crisis Teams (Must have MediCal, Medicare,or Private insurance): All Care Behavioral Health 888.425.5227 Hollywood Community Hospital Van Nuys 800.565.0558 Mission Community Hospital Panorama City 800.608.4824 Northridge Hospital 800.345.2747 Sun Valley Pacifica Hospital 800.522.1154
- **Suicide Hotline: 877.727.4747 24 Hours**
- Teen Line: 310.855.HOPE 6 p.m. to 10 p.m.
- Threat Management Unit LAPD: 213.485.4188

Day Treatment Programs
- Ask your area Mental Health Center on back page.
- See Partial-Hospitalization Programs.

Dental
- Dentists Who Accept Medical: 800.322.6384
- Valley Medical Dentists: Mission Hills: P. Kohanoff 361.8777 Studio City: I & T Kolodner 761.9528 Van Nuys: Alain Gabbay 988.5722
- Donated Medical Services Program (For Disabled Who Can't Afford To Pay) 800.872.6176

Depression & Bipolar Disorders
- Lithium Information Center 608.827.2390
- Los Angeles Depressive Bipolar Support Alliance 310.535.7775 PO Box 2038, North Hills 91393 **Area Meetings: Glendale** Adventist Hospital 1500 Wilson Terrace, Psych Unit 1 Thursday 6 p.m., 323.254.6492; **Granada Hills**, 10605 Balboa, Thursday 2-4 p.m.,288.2611; Northridge 9650 Zelza, Room 141,Thursday 6:30 p.m.,599.7697; **West Hills**, 22450 Sherman Way, Friday 7 p.m., 709-4217; **Van Nuys**, 14545 Sherman Circle, "Ups and Downs", Room 33, Wednesday 6 p.m.,780.8279
- UCLA Adult Outpatient Clinic, 300 Medical Plaza, 2nd Floor Conference Room 1 Clients 6 p.m. Monday Families 7 p.m. 2nd Wednesday 323.202.8884
- National Depressive Bipolar Support Alliance (DBSA) 800.826.3632 www.dbsalliance.org DBSA Peer Support www.peersupport.org
- National Foundation for Depressive Illness 800.248.4344
- Postpartum Support International 805.967.7636

Developmental Disability
- Los Angeles Regional Center 213.383.1300

Dual Diagnosis
Mental Illness plus Substance Abuse
- BRIDGES, Inc. Dual Diagnosis Residential Canoga Park 999.0143 Sylmar 362.7811
- IC Treatment Center MediCal Reseda 776.1755
- Center for Family Living 4 p.m.Wednesday14545 Sherman Circle, Van Nuys 901.4854
- San Fernando Mental Health Center 5:30 p.m., Tuesday, 10605 Balboa, Granada Hills 832.2400
- Victory Wellness Center Tuesday thru Friday 11:30 a.m. and 2 p.m. 14411 Vanowen, Van Nuys 989.7475
- Santa Clarita Mental Health Center 6 to 7:30 p.m. 23501 Cinema Dr. #200, Santa Clarita 661.288.4800
- Mission Community Hospital 800.608.4624
- Portals Dual Recovery Residential,LA 213.639.2500
- River Community Residential Treatment 628.910.1202
- Tarzana Treatment Center 996.1051 extension 14
- Twin Peaks Dual Recovery Residential, LA 213.381.8447

Eating Disorders
- Anorexia and Bulimia Association 212.575.620
- National Eating Disorders Association 206.382.3587 www.nationaleatingdisorders.org

Estate Planning & Mental Illness
- Attorney Ron Berman (AMI Speaker) 593.5050
- PLAN (Planned Lifetime Assistance Network) a MHA and California NAMI Trust Administration and Case Management Program. Carla Jacobs 888.574.1258

Family To Family NAMI Course
- Free. Contact Milton Decker 704.5643

Groups
- Alzheimer's: LA Meetings 213.938.3370
- Brain Injury: LA Caregiver Resources 800.540.4442
- Co-Dependents Anon SFV Meetings 906.6608
- Mental Health America LA 562.285.1330 Antelope Valley, Judy Cooperberg 661.726.2850
- National MHA 800.969.NMHA
- National Council on Problem Gambling 800.522.4700
- National Stuttering Project 800.237.0717
- **World Fellowship Schizophrenia (Canada)** 416.961.2855 www.world-schizophrenia.org

Health Care - General
- Planned Parenthood 800.230.7526
- Valley Care, LA County Health Services: Burbank, 557.3705;Mid-Valley,947.4000; North Hollywood, 766.3981; Pacoima,947.4000 San Fernando, 837.6969; Sepulveda,830.1870; Tujunga, 352.1417 Medicare/MediCal ability to pay or nothing

Hearing Impaired + Mental Illness
- GLAD Private, nonprofit information 213.478.8800
- Telephone Bridge To Hearing 711

Homeless + Mental Illness
- Conerstone, 5950 Cedros Avenue (at Oxnard),Van Nuys, 91411 Phone 901.4836
- Lutheran Social Services, Van Nuys, Help and Housing 901.9480
- Connections, West Valley Mental Health Center 598.6900 extension 6974
- Gay/Lesbian LA Service Center 323.993.7400
- Homeless Access Info Center 9 to 5 Weekdays 982.4091
- Homeless Advisory Mental Health Dept. 213.738.4148
- LA Family Housing,Gatekeeper: E. Moran 832.2400
- Women's Care Cottage, North Hollywood 753.4580
- Winter Shelter Hotline 800.548.604

Hospitals With Psychiatric Units
- Glendale Adventist 409.8294
- Henry Mayo Newhall - Valencia - 888.383.0558
- Hollywood Community of Van Nuys 800.565.0558
- Mission Community - Panorama City - 800.608.4624
- Northridge Hospital,Northridge 885.5484
- Olive View Medical Center, Sylmar 364.3432
- Pacifica, Sun Valley 767.3310
- Tarzana Treatment Center, Drug/Alcohol 996.7019

Housing
- List of SFV Board and Cares with DMH funding contracts available at Van Nuys meetings listed on Page1.
- California Board & Cares by Zip Codes www.ccld.gov
- Community Care Licensing-SFV. State regulators of care homes: 818.598.4334
- Community of Friends. Vacancies 213.480.0809
- Low Income Utility Discounts: Gas 800.427.2200 #8; Telephone 800.772.3140; DWP 800.342.539
- Fair Housing Hotline 800.424.8590 State: 800.233. 3312 San Fernando Valley 373.1185
- DMH Patient's Rights, Residential Care Advocate
- Barbara Leifer 213.738.4612 (Continued on Page 7)

- Hillview Village Apts.,Permanent low cost housing for adults capable of independent living. 896.1161
- Lutheran Social Services, Van Nuys 901.9479
- Roommate Socials 4th Friday, 1:30 p.m. 988.9525
- Rural Residential: Anne Sippi Ranch near Bakersfield 661.871.9697
- Changing Options near San Diego 760.789.7299
- Section 8 Advice LACDMH 213.637.2347 and Housing Liaison at your MHC listed on last page.
- Transitional Housing six to nine months 374.4080
- United County Housing Corp. May help prevent utility cut-off for low income persons. 800.342.5397
- Utility Assistance Program Dial 211.
- Utility Tax Exemption low income (less than $16,700 annually) and disabled 800.342.5397

Information

- LA County DMH Access Line 800.854.7771
- Federal Help: 800.688.9889 Copy of Consumer Information Catalog:888.878.3256
- LA County Information Lines:Dial: 211 for Human Services; 311 for City Services; TDD (Deaf): 800. 660.4026
- Self-Help Group Directory 877.742.7349

Insurance

- California Insurance Department 800.927.HELP
- California Low Cost Auto Insurance 800.622.0954

Jails and Courts

- DMH Court Program 626.403.4370
- DMH Jail Reception Center 213.893.5475
- "Friends Outside" LA County Group626.795.7653
- Inmate Location LA County Sheriff's Department 213.473.6100 or www.lasd.org; Internal Affairs To Report Abuse 800.698.8265
- Juvenile Hall, R. Lawrence Smith 323.226.8829
- Juvenile Hall Mental Health 323.226.8829
- Twin Towers Correctional Facility, 450 Bauchet, Street, LA 90012
  Jail Mental Health Administration 213.893.5427
  Men's Outpatient (in jail) Program 213.473.6183
  Women's Outpatient (in jail) Program 213.893.5377

Legal

- California Courts Self-Help www.courtinfo.ca.gov/selfhelp
- Crime Victim Compensation 800.842.8467
- Mental Health Advocacy Service 213.389.2077
- Protection & Advocacy, Inc. (PAI) 800.776.5746
- Valley Storefront Legal Services 769.0136

Legislators, San Fernando Valley

- Name of Your Legislator 800.481.8683
- Governor Arnold Schwarzenegger (R) 213.897.0322 State Capitol, Sacramento 95814
- Assembly Members Address: Capitol Building, Sacramento 95814
- Cameron Smyth (R-38) 661.286.1565
- Felipe Fuentes (D-39) 818.504.3911
- Bob Blumenfield (D-40) 818.904.3840
- Julia Brownlea (D-41) 818.596.4141
- Mike Feuer (D-42) 310.285.5490
- Office Vacant (43) 818.558.3043
- Senators Address: Capitol Building, Sacramento 95814
- Tony Strickland (R-19) 805.306.8886
- Alex Padilla (D-20) 818.901.5588
- Carol Liu (D-21) 626.683.0282
- Fran Pavely (D-23) 310.314.5214

U.S. Representatives

- Address: U.S. House of Representatives Washington, DC 20515
- Xavier Becerra (D-30) 213.483.1425
- Howard L. Berman (D26) 9947.200
- Howard P. McKeon (R25) 661.254.2111
- Adam Schiff (D27) 626.304.2727
- Brad Sherman (D24) 501.9200
- Henry A. Waxman (D29) 323.651.1040

U.S. Senators

- Address: U.S. Senate, Washington, DC 20510
- Barbara Boxer (D) 415.403.0100
- Dianne Feinstein (D) 415.393.0707

Los Angeles County Supervisors

- Mike Antonovich (5th) 213.974.5555
- Zev Yaroslavsky (3rd) 213.974.3333

Los Angeles City Council

- Address: c/o City Clerk, Room 395 City Hall 200 North Spring, Los Angeles 90012-4081
- Paul Krekorian (2nd) 818.755.7676
- Dennis Zine (3rd) 818.756.8848
- Tom Labongel (4th) 818.755.7630
- Paul Koretz (5th) 818.971.3088
- Tony Cardenas (6th) 818.778.4999
- Richard Alarcon (7th) 818.756.9115
- Bill Rosenthal (11th) 213.473.7011
- Greg Smith (12th) 818.756.8501

Managed Care Complaints

- Department of Mental Health Care 888.HMO.2219

Medication Information

- FDAReport on Adverse Med Reactions 800.532.4440
- Free Medications for Needy Without MediCal 800.762.4636. Abilify 888.477.2669 Clozaril 800 447 6673 Zyprexa 800.545.6962 Risperdal 800.652.6227 www. needymeds.com or www.pharma.org(202.635 3400) www.rxhelp4ca.org
- LA Free Clinic Medication Information Line 310.854.MEDS 9 a.m. — 5 p.m. No Charge

MediCal Benefits (See Benefits)

Mental Health Dept., LA County (LACDMH)

- Access and Referral 800.854.7771
- Clinics SFV area: See last page of this newsletter.
- Director: Marvin Southard, DSW 213.738.4601 Chief Deputy Director: Sheila Shima
- Emergency Outreach Bureau: Gary Walendzik,LCSW 213.738.3433. PMRT Complaints or Comments
- Employee Phone Numbers: 213.738.4775
- Family Advocates: John Griffin 213.637.2311 and Lewis Webet 213.637.2353
- Homeless/Housing Bureau 213.637.2301
- IMD Administrator 323.226.4447, ext 4431
- Jail Mental Health Program Head: Stephen Jacobson, PhD (See Jails and Courts)
- LA County Mental Health Managed Care Plan 800.854.7771
- Legislative: Martha Guerra, MSW 213.639.6766
- Medical Director: Roderick Shaner, MD 213.738.4603
- Patients Rights Chief: Carol Mathews 213.738.4873
- Sector Chief SFV, Santa Clarita Valley and Glendale: Ron Klein, PhD 818.598.6900
- Service Area Advisory Committee (SAAC) meets 9 a.m., 2nd Thursday 19020 Vanowen. All Welcome.

Missing Persons

- DMH Project Search: 213.738.2524
- Search Reports, Inc.: 201.288.4445 Social
- Security Locator Service: 800.772.1213

Money Management

(See "Benefits")

- Consumer Credit Counseling (free) 800.750.2227

Obsessive-Compulsive Disorder

- Obsessive Compulsive Foundation 203.878.5669
- Kosins,MD, Mark S. (Affiliated Psychiatric Med Grp), El Monte. Especially OCD & Panic Disorder Adults and Children Medicare/MediCal Sliding Scale 626.307.8420
- OCD Foundation of California: 818.990.4830
- OCD information from Upjohn Co. 800.639.8462
- Tourette Syndrome Association 800.237.0717

Older Adult Mental Illness Services 60+

- LA County DMH Genesis Program 213.074.7779

Panic Disorder

- Phobics Anonymous, PO Box 1180 Palm Springs 92263
- National Center for Post Traumatic Stress Disorder 802.296.5132

National Institute of Mental Health 888.826.9438

Partial-Hospitalization Programs

(Like in-patient hospital day programs, but patient leaves each night. Transportation and lunch provided. Medicare or private funds required.)

- Glendale Partial Hospital Program 240.1155
- Henry Mayo Hospital, Newhall 661.253.8000
- Hollywood Hospital of Van Nuys 800.565.0558
- Mission Hospital, Panorama City 904.3635
- Sherman Oaks Hospital/Health Center 907.2835
- Northridge Hospital, Northridge 885 5348

Psychiatrists

Accept MediCal Only or With Medicare

- Basta, Fawzy, M.D. Northridge 886.5628
- Consolver, J Paul, MD. Sherman Oaks 784 8270
- Gama, Feliza, M.D. Northridge 886.5628
- Reyes, Arjvn, M.D. Canoga Park 776.8733
- Vukov, Judith, M.D. Glendale 956.3207
- There are also psychiatrists who accept "MediCal only" or "ability to pay" at public mental health centers listed on back page of newsletter.
- Our criteria for listing psychiatrists is that they practice in the San Fernando Valley NAMI service area and accept patients who have MediCal only.
- * DMH Access: 800.854.7771. Ask for private psychiatrist in your area who accepts MediCal only.
- MHA Access: 213.413.1130. Ask same as above.

(Continued on Page 8)

NAMI San Fernando Valley is ...

- people who care
- the newsletter
- expert speakers
- books and videos
- resource lists
- free pamphlets
- free classes

NAMI SFV can be ... "the beginning of hope"

Please Join

Send this form and your check payable to NAMI SFV to: NAMI San Fernando Valley 14545 Sherman Circle Van Nuys 91405

NAMI San Fernando Valley

ANNUAL MEMBERSHIP FORM

(Our funding is from dues, LA NAMI Walks, grants, small donations. Please be generous. Tax deductible.)

☐ New ☐ Renewal

☐ 3-Way Membership $35 includes NAMI SFV, State, National memberships & newsletters.

☐ Benefactor Membership* $50 - 99 ☐ Patron Membership* $100+

☐ NAMI SFV Membership $15 includes newsletter

Name(s) ______

Address (if new) ______

City ______ State ______ Zip ______ Date ______

Telephone ______ E-Mail ______

Relationships: Your loved ill one is: (circle one): Adult Child - Minor Child-Sibling - Parent - Self

LOW INCOME MEMBERSHIP: ☐ Individual on SSI/SDI $1 ☐ I can't afford anything

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CRISIS NUMBERS

FOR SAN FERNANDO VALLEY, SANTA CLARITA VALLEY & GLENDALE

- IF SPEED IS REQUIRED, CALL 911

- PSYCHIATRIC MOBILE RESPONSE TEAM (PMRT) (If patient is a dangers to self or others but will not seek help voluntarily.) Week Days 8-5: 818-832-2410. All other times: 800-854-7771.

- PUBLIC MENTAL HEALTH CENTER: For a daytime, weekday crisis (if the patient will walk-in): call first, then go to appropriate public center shown at right above.

- PRIVATE CRISIS TEAM (If patient has Medicare, private insurance or funds) see CRISIS heading in Resources Directory

Suicide Hotline 1-877-727-4747

NAMI San Fernando Valley
San Fernando Valley Community Mental Health Center, Inc.
14545 Sherman Circle
Van Nuys, CA 91405

ADDRESS SERVICE REQUESTED

Non-profit Org.
U.S. Postage
PAID
Van Nuys, CA
Permit No. 1328

TIME DATED MATERIAL

Psychologists

- SFV Psychological Association 905.0410
- Psychologists who accept MediCal and/or Medicare:
- Abel, Bonnie, PhD, Glendale 352.9327
- Bitter, Edward, PhD Tarzana 345.2341

Restraining Orders

- Court Domestic Violence Clinic 576.8884

Spanish Language Services

- SFV AMI Spanish Language contact Ana Vega-Woller 994.6747 Press # and leave message for Spanish language call back.
- San Fernando MHC Spanish Language Family Group, Jose Quilez 363.3716
- El Central de Armistad: 898.0223
- Instituto Latino Para Padres, N.H., 501.4447
- Spanish Client Coalition: 213.637.2368

Stigma

- NAMI e-mail Stigma Buster Network www.nami.org Scroll to Stigma Alert listing. Click for sign up box.
- National Stigma Clearinghouse, 245 8th Ave., New York, NY, 10011 Phone 212..255.4411

Suicide

- Suicide Hot Line: 1.877.727.4747 (24 Hours)
- America Suicide Foundation Survivor Groups 800.531.4477
- Information on Survivor Support Groups 202.237.2280
- Survivors of Suicide, 3251 North 78th Street, Milwaukee, WI 53222
- Suicide Website: www.save.org

Therapy

(Also see Psychiatrists and Psychologists)

- California Family Ability To Pay Basis 386.5615
- Jewish Family Services (non-sectarian) 464.3333
- Kalcheim, Sid, MFCC, Tarzana 310.312.0771 Young Adults with mental illness groups. No MediCal/Medicare
- Kern, Don, MFCC, Bipolar Disorder Specialist. No Medical/Medicare 591.1590
- Personal Growth Institute Tarzana Multi-lingual, Inc. Armenian, Farsi, Hebrew, Russian, etc. 609.9989
- SFV Counseling Center 341.1111 for well family members. Ability to pay basis.
- Recovery, Inc. Emotional self-help meetings in SFV. Shirley 994.5455. www.recovery-inc.org
- Valley Trauma Center CSUN 772.9981
- Wilson, Frances, PhD Sherman Oaks & Santa Clarita 990.0221 Severe Mental Illness Experience.
- Deak, Gabi, MSW, LCSW, CBTSpecialist. Sliding scale basis, 310.479.4224

Transportation for Disabled

- Access 800.827.0829
- CityRide 808.RIDE
- Taxis: United 800.521.8294, City Cab 780.1000
- Taxi Voucher Referral 800.431.7882 TDD 431.9731

Veterans

(No Cost Services)

- Lutheran Social Services 994.3731
- Sepulveda VA Mental Health Clinic 891.7771 ext 9027
- Sepulveda Veterans Center 892.9927
- Veterans HealthCare Enrollment 877.222.VETS

Violence Against Women

- Family Violence Project (shelters, etc.) East SFV 505.0900 West SFV 887.6589
- LA Domestic Violence Hot Line 800.339.3940

Vocational Rehabilitation and Work

- Los Angeles County Department of Mental Health Rehabilitation Unit 213.738.2819;
- California Department of Mental Health Rehabilitation Unit, Van Nuys 901.5024;
- Volunteer Center SFV Volunteer Jobs 908.5066;
- Clients SFV Community MHC 902.5312; San Fernando MHC 837.7158; West Valley MHC 598.6948
- Victory Wellness Center 989.7475

Websites, Mental Illness

- California NAMI www.namicalifornia.org
- NAMI national www.nami.org
- NAMI SFV www.namisfv .org
- Treatment Advocacy Center www.psychlaws.org
- California Resources www.networkofcare.org

- END -

Area Mental Health Centers

Center for Family Living
14545 Sherman Circle, Van Nuys, 91405
Tel. 818.901.4854
(Serving Encino, Sherman Oaks, Van Nuys)

Hillview Mental Health Center
12450 Van Nuys Blvd., #200, Pacoima, 91331
Tel. 818. 896 .1161
(Serving Arleta, Pacoima, Lakeview Terrace, Sun Valley Sunland, Kagel Canyon)

MacDonald Carey East Valley Mental Health Center
11631 Victory Boulevard, #203, North Hollywood, 91606
Tel. 818.908.3855
(Serving North Hollywood, Studio City, Toluca Lake, Burbank west of Buena Vista, Universal City)

San Fernando Mental Health Center
10605 Balboa, Boulevard, Granada Hills, 91344
Tel. 818.832.2400
(Serving Sylmar, San Fernando, Mission Hills Granada Hills, North Hills, Panorama City)

Santa Clarita Mental Health Center
23501 Cinema Drive #210, Santa Clarita, 91355
Tel. 661.288.4800
(Serving City of Santa Clarita, Newhall, Valencia Bouquet Canyon, Saugus, Val Verde, Canyon Country, Castaic, Sulpher Springs, Agua Dulce)

Verdugo Mental Health Center
1540 Colorado Street, Glendale, 91205
Tel. 818.244.7257
(Serving Glendale, Montrose, Verdugo City, Eagle Rock, Glassell Park, Atwater, La Crescenta, Burbank-east of Buena Vista, La Canada/Flintridge)

West Valley Mental Health Center,
7621 Canoga Avenue, Canoga Park, 91304
Tel. 818.598.6900
(Serving West Lake Village-LACounty, West Hills, Chatsworth, Canoga Park, Northridge, Porter Ranch, Winnetka, Woodland Hills, Tarzana, Reseda, Hidden Hills Calabasas, Agoura Hills)

Errors In This Directory?
Call 818.994.6747