NAMI Santa Cruz County
National Alliance on Mental Illness

National Alliance on Mental Illness of Santa Cruz County

Task Force Report

Advocacy Review of Acute Crisis Services Provided in Santa Cruz County

October 2017

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INTRODUCTION - Formation of NAMI's Task Force

This report is a summary of the findings and recommendations of the Acute[1] Crisis Services Task Force formed by Santa Cruz NAMI members in the spring of 2017.

NAMI is a national grassroots advocacy and educational organization, with both state and county chapters, whose primary mission is the building of better lives for those individuals in our country with mental health conditions, particularly severe conditions.

NAMI's role as an advocate can take various forms: public policy, support for research, advisory for legislative action, support groups, etc. A core responsibility is for NAMI to listen and support the challenges families face in seeking help for their loved ones. In this role, the NAMI chapter has heard numerous concerns regarding how acute mental health crisis is managed in this community.

In particular, members of the NAMI board (based on the experiences of families) have felt that the conditions and processes of the Crisis Stabilization Program (CSP), operated by Telecare Corporation under contract and in partnership with Santa Cruz County Mental Health Services, were concerning. Specifically, the process and decisions made in evaluation of individuals who are detained involuntarily or who come voluntarily to the facility drew attention. Families were experiencing frustration in getting the help they needed. These issues are addressed in this document, including a concern regarding the release of Sean Arlt, who later was killed by police.

A marked increase in episodes of family dissatisfaction developed in late 2016 following the resignation of the Telecare facility administrator, along with many other staff. There had been significant leadership turnover; it seemed that services were in disarray. More and more concerns were made through the NAMI warm-line from families distressed about getting treatment and stability for their family members. We felt urgency for action. NAMI members submitted written and verbal stories of their challenges with mental health services locally, and in particular with the Crisis Stabilization Program. Community conversations, including with elected officials, ensued in order to find the best vehicle for advocacy. In the end, a Task Force was created that would focus on the most pressing issue, which was in the acute mental health crisis arena, and in particular evaluation and treatment services provided in the CSP. In late May of this year, NAMI wrote a letter to the CEO Anne Bakar of the Telecare organization, voicing the concerns and requesting action. To Telecare's credit, Ms. Bakar provided a quick response to our request for meetings. Ms. Bakar oversees a very large organization, with programs in virtually every county in California and in many other states. She expressed deep concern and immediately agreed to participate in these meetings, bringing in top leaders of the Telecare organization.

The needs for improvement were determined to be significant and the services not to the standards of the community, and as it turned out, not to the standards of the Telecare Corporation itself. Strong skilled leadership is important for operating the program, and this and other issues needed to be

[1] *Acute* refers to something expressed to a severe or intense degree.

addressed. We were impressed by Telecare's transparency in acknowledging the problems, and the rapid action of hiring a highly qualified regional director of acute services, who then hired both a clinical administrator and a director of the CSP, both also highly qualified. Improvements in the culture of care are noticeable already. We offer appreciation to Santa Cruz County Mental Health Director Erik Rivera, Chief Psychiatrist Vanessa de la Cruz, Adult Services Manager Pam Rogers-Wyman, and Quality Improvement Program Manager Karolin Schwartz, who attended these meetings and were helpful in reinforcing the need for improvements.

This document will focus also on what we have learned about the systems design that drives the scope and quality of this vital safety-net service in our community. We believe that many problems in our mental health care are systemic and reflect unintended consequences of the current federal and state structures of funding and control. We found validation for this in the investigations of others, including the California Healthcare Foundation. There are flaws in the local design that are difficult to resolve due to a sharp division of services from public to private – an unnecessary burden on our community to try and negotiate. Essentially, we find the mental health system in California to be a complex, confusing, and poorly designed system that is in need of change.

We call on our county mental health leadership and elected officials to help advocate with federal and state representatives to address these structural problems. Access to care at the appropriate time and with needed supports such as housing and rehabilitation are essential. These services are critical; literally lives are at stake.

It is not the role of NAMI to regulate the practices nor to write the policies for treatment providers, but to advocate for their improvement. This report is written in order to fulfill the advocacy responsibility of our organization, by sharing these concerns and the responses to these concerns. In this way, we provide education to the community and hopefully promote an ongoing dialogue towards improvement in how individuals experiencing an acute mental health crisis are cared for in Santa Cruz County.

We would like to further acknowledge the professionals and other staff at Telecare, County Health and Mental Health Care Services, local hospitals and all other providers in our community who have dedicated themselves to this field. Our loved ones have benefitted from their efforts, and we are grateful.

NAMI Task Force Charge for Acute Crisis Services

(Reaffirmed September 2017 by NAMI Board)

1. Provide awareness to both County and Provider to the areas of dissatisfaction expressed to NAMI by the families and consumers of crisis services in Santa Cruz County.

2. Work collaboratively with those agencies towards building improvement in the service experience and the quality of care supplied by the Crisis Stabilization Program (CSP), by providing information on current experiences and suggestions for improvement.

3. Through the assistance of a technical advisor, ask questions into the policies/practices/leadership at the CSP in advocacy of improvement in care.

4. Learn the capacity of treatment at the facility, and the contributing factors to overcrowding, out-of-county placement, and extended stays.

5. Learn about the impact of any workforce issues, including recruitment, pay, turnover, training and competencies that may impact the quality of services.

6. Review the facility leadership planning for impact on quality of services, culture of care, and adherence to standards.

7. Determine the role of Santa Cruz County in the quality oversight of the CSP/PHF facility, the day-to-day operations, and funding adequacy for optimal care.

8. Study the level of comfort and dignity in the environment of care and the impact on services provided and the experience of the consumer and family.

9. Examine the relationships of the CSP with other agencies involved in the crisis management of the consumer: police, sheriff, hospital emergency departments, El Dorado Center, and Telos Crisis Residential Center.

10. Explore the mental health system existing structure for how it impacts provisions of mental health crisis services.

11. Explore follow-up care for individuals not admitted to, or released from, the CSP.

12. Explore the CSP culture regarding the encouragement of family engagement, and barriers to this engagement.

13. Provide an advocacy-focused report to the NAMI board, membership, and the Santa Cruz County community on the information above.

A Review of Mental Health Acute Care Services

History & Current

There is an increased attention by our community, and by communities everywhere, on issues regarding mental health and addiction conditions. More and more, individuals who've experienced severe conditions and their families have come forward to talk of these experiences. Many are participating in efforts to improve services through active advocacy. This has opened up the mental health dialogue to look at how the system of services are structured, what the funding streams are and how they are spent, and why is it seemingly so hard to get treatment to those who most need it.

At NAMI, we know there is a great amount of need. We know this from our personal experiences, the many phone calls we receive on our "warm line," the obvious presence of so many individuals who are homeless and mentally ill in our streets and parks, the episodes of drug overdose coming to our emergency rooms, and the number of mentally ill individuals who reside in our jail. We know that this is not unique to our community, and that leaders in multiple agencies--including public health, mental health and law enforcement--have been working to address these issues. The need that we hear constantly expressed by families is in finding and receiving accessible and effective interventions that will help our loved ones heal and move forward with their lives.

This report is focused on the emergency mental health (crisis) services in our county, and in particular the evaluation and treatment services provided at the only facility in the county with 24-hour mental health evaluation capability. The Psychiatric Health Facility and Crisis Stabilization Program are the single designated settings for mental health assessment (5150/5585 W&I code) and for treatment of people on an involuntary basis (Welfare and Institutes Code 5250 certification process). Dominican Psychiatric Unit had this designation before its psychiatric unit closed.

Many things are easier to understand when they are placed in context, and in terms of acute crisis there is a historical context that is informative to the current situation. What we've come to recognize is that there are many factors that led to the design of these services, and that there are financial structures in place that have driven the way care is provided today. We have learned that this design does not always align with the needs of populations within our community, and significant changes are needed in this design in order to better fill these needs.

For better and for worse, mental health acute care was provided differently a few decades back, with more accessibility to treatment in the acute care setting and the cost of treatment far lower (even after accounting for inflation). It was not without flaw: there was an over-reliance on sedating medications, higher use of restrictive care practices, and less recognition of the importance of the patient/family participation in treatment and the value of peer support. Many things have improved.

In California, the closing of state hospital beds beginning in the 1960s was supposed to be met with greater availability of psychiatric beds in local communities and other services that would replace the long-term institutionalization of people with severe mental illness. Community hospitals throughout the state did begin to provide psychiatric care, and in that era Santa Cruz County provided inpatient services at the hospital located on Emeline Street. The county eventually closed both its medical and

psychiatric hospital services, becoming the contractor rather than the provider of acute care treatment, and in 1983 Dominican Hospital opened up a new inpatient facility for mental health.

Until the mid 1990's, patients were brought from their homes, the streets and community at large to the Dominican mental health unit if they were in a crisis state. There were 28 crisis beds, (whereas now there are only 16). The state paid the Medi-Cal bills under a fee-for-service agreement with federal matching funds (50%) and county realignment funding helped defray the cost. The State dismantled the State Mental Health Department, absorbed it under all Health Care, and has now transferred the funds and the authority to the Counties

During those years Dominican treated a higher percentage of privately insured patients, and those insurance companies began to aggressively manage and deny payment for care. However, because there were more beds allowed within a hospital based inpatient program there was reimbursement through Medi-Cal, MediCare, and private insurance.

The state applied and was granted a federal Medicaid change allowing counties to become managed care plans and have full responsibility for the entire continuum of care from state hospital beds to local outpatient care. Core elements of treatment access are required, but many smaller and rural communities could not afford a full range of treatment options or adequate capacity. Local control allowed more development of residential treatment, case management and rehabilitation services including those in supported housing. These plans varied county-to-county (as they still do), with some counties tightening inpatient utilization and expanding residential treatment and a range of different outpatient care. In general Santa Cruz is seen as having a range of different levels of care, but capacity is insufficient at most levels of care, due to lack of options for development of new housing beds because of loss of Redevelopment Funds and state allocations for funding.

Length of stay in the PHF averages 5-6 days. Medicare, Medi-cal, and private insurance only authorize payment for services that meet "medical necessity". An improvement has occurred in determination of length of stay. In the past the length of stay could be dictated by the payment source's determination of "medical necessity". Currently, the payment sources (Medi-Cal, Medicare, Private insurance) do not determine the length of stay. However, it appears that the shortage of beds and small space creates pressure to move people out quickly or to not admit, along with a prevailing philosophy that hospitalizing should be avoided. The other difficulty is that the 16 beds are prioritized to be available for people who have Medi-Cal and who are in the SC County system of care already, or eligible. Approximately one third of the people who come to the CSP, and are determined to need hospitalization, have to be sent out of our County to other locked facilities such as Fremont Hospital.

The jails and prisons are acknowledged to house large numbers of mentally ill inmates, but how much of this is related to other factors? It is not disputed that now there is a higher bar set for civil commitment in hospitals, but there are also more outpatient options for individuals with serious mental health conditions, including crisis residential services, innovative programs operated by individuals with lived experiences, intensive case management, etc. One truth that independent analysts, county mental health directors, and others seem to fully agree on is that the funding necessary to provide enough capacity and flexibility to meet individual patient needs from inpatient care to community outpatient services has not been sufficient. This is especially true in regards to

housing needs – it is an incredibly difficult process for an individual with a serious mental illness and chronic homelessness to achieve recovery, absent a pathway to affordable and supported housing. In the 1990's and 2000's, many public community hospitals (high concentrations of Medi-Cal) closed the acute psychiatric services which they had opened in response to the call for closing state institutions. Eventually, Dominican Hospital announced it too would close its psychiatric services. And while Dominican provided a long notice as well as a contribution of $5 million dollars to fund another option, those options were very limited.

"The IMD Exclusion", A National Issue since 1988: In order to qualify for Medi-cal and MediCaid reimbursement, there are only two options for inpatient psychiatric services (1) Psychiatric units that are in a large general acute care hospital, and (2) Psychiatric Health Facilities (PHF) which are free standing small hospitals (16 beds) which focus on acute mental health care. Although licensure would allow any size psychiatric facility, Medicaid law prohibits use of funding to larger that 16. This is called the IMD Exclusion. (IMD: Institutions of Mental Diseases)

We learned from our discussions and review that this federal regulation is a serious issue and the root cause of some of the structural problems we see in our local care system and in many other counties. During the Obama administration there was a call to change this IMD exclusion, to allow Medi-Cal to be billed for acute care facilities with more than 16 beds, and with lengths of stay of 30 days or less. But, unfortunately, that consideration is now on hold.

During the final years of Dominican's operation, a gradual decrease from 28 beds to 18 beds ensued. Dominican BHU originally operated with 28 beds. In 1999 California passed a law, AB394, that instituted nursing ratios for various medical services, including psychiatric settings. The nursing ratio for a psychiatric unit is 1 RN registered nurse to 6 patients. Dominican reduced the bed capacity from 28 to 24 in response to this law, in 2003. Up to 2012 the BHU operated with 24 beds. Dominican Hospital reported a five million dollar a year loss on the BHU, over a several year period. This ultimately led Dignity Health, who acquired the Dominican Hospital, to close the service. A review of bed utilization over the previous three years 2007-2011 showed an average daily census of 14.2 patients per day, which contributed to Dominican choosing to reduce to 18 beds in 2012, due to financial loss, and also led to the County's conclusion that the 16 bed capacity of the new PHF would be adequate.

Limited Options for Crisis and Inpatient Services

Given little choice, the county turned to a Psychiatric Health Facility (PHF, pronounced "puff") license because under this license, it was possible to receive the federal matching dollars for the state Medi-Cal expenses. The challenge was that only 16 beds could be provided to the community, under federal law, and still be eligible for the federal reimbursement.

Since Dominican had been providing crisis stabilization services as well, a solution for that needed to be found also. The county chose to combine these two needs into one building, with side-by-side services: a Crisis Stabilization Program (CSP), along with the PHF. This provided many advantages in terms of improved coordination of care for the Medi-Cal patient.

The PHFs have different licensing requirements compared with hospitals because they focus only on mental health stabilization and treatment, and have more rehabilitation and therapy staff and less nursing capacity. PHFs can only be opened with the permission of the counties where they reside, giving the county strong leverage over the operations.

A Design that Works Better for Some than for Others

Where some problems were being solved, others were being created. One problem with less bed availability is limited access for private insurance patients. People who are privately insured can be treated if there is capacity and the insurance program allows payment; however Medi-Cal recipients are prioritized. If they are admitted to the PHF there are challenges with transitions to private insurance funded care for after care. Some insurance programs have closed networks, like Kaiser and VA so those patients are sent from CSP to the Kaiser PHF or the VA hospital. Other County after care or diversion programs are rarely covered by private insurance, and the county is not set up for this. These patients are often transferred out of county due to lack of available beds at the PHF. The impact of this for families is significant. They must travel out of county, sometimes great distances, to participate in the care of their loved ones. These patients are subject to multiple ambulance rides at times: to/from the emergency department for lab draws and medical clearance, and then off on another trip to a hospital or PHF willing to accept them. Out of county programs may have little awareness of the outpatient and aftercare services available in the Santa Cruz community. This makes transitions in care difficult and risk or re-hospitalization higher.

Because the 16-bed limitation only applies to the matching of federal funds for the public pay Medi-Cal patients,(which includes all disabled individuals and low income individual), this has the greatest impact on the availability of these services for the non-public pay patient. The State waiver and model emphasizes providing services to persons at the least restrictive, appropriate level of care. This is based on a major federal case called the Olmstead Act. The expectation is there is a rich set of alternative services to locked care, and only when safety is at risk, would someone be put into locked involuntary treatment. The assumption is there is enough capacity and intensive alternatives such as transitional residential treatment with 24 hours supports to offer sound clinically appropriate alternatives. Unfortunately as previously discussed, there are not enough alternative beds for smooth transitions and levels of support. The county made efforts to address this concern on the front end: requiring that the contractor (Telecare) seek contracts with insurance payers, but not all payers will contract with the County PHF, for reasons not reviewed in this report. However, the larger issue is that there are simply not enough crisis care beds and not enough capacity at the lower levels of care for quality aftercare supports.

A "Two -Tiered Medi-Cal System"

We have a two-tiered system. The Medi-Cal patients who are experiencing a mental health crisis but who are not "seriously mentally ill" (SMI), are challenged by the system of care. These individuals are considered "mild to moderate" in their severity, and are not candidates for the regular County programs which are geared towards recovery of a serious mental illness. These Medi-Cal patients with mild to moderate treatment needs can be referred to Beacon Health Options mental health services, which is a network of therapists and other mental health providers who provide services under a contract with County Behavioral Health and funded through the Central California Alliance for Health,

with Medi-Cal funds. Beacon also operates services under County contract out of the County Primary Care Health Clinics in Watsonville and Santa Cruz.

This is a very confusing system for persons with mental health needs and families and often people's needs change from mild/moderate to severe and back again. So the potential for being bounced between providers and systems is significant and access to psychiatry is critical. This was part of the State Medi-Cal Plan for 2020 where they want to see more behavioral health integrated into the primary care sites and health homes. While the vision is positive, on the ground it does not work well for many patients and families and causes great confusion.

This situation is again widely acknowledged as a serious problem, and so efforts are being made to correct this at many levels. Locally, the Central Coast Alliance and the county Mental Health Plan have been working on solutions, as these patients may flow between the two based on their symptoms.

The result of all this is a variance between what the community expectations are for services and what the design of services is. This is at the root of many complaints we receive and we believe this must be continually openly addressed as an issue, free of blame. NAMI encourages the community to understand that it is not the fault of the county health system that these problems exist. Our health care leaders are in the unenviable position of doing all they can to mitigate, as they are essentially the "owners" of the state mental health system for this community. This is not the system anyone would have designed from scratch.

The good news in Santa Cruz County is that the community is engaging. Recently leaders from several organizations, Emergency Room physicians, Telecare leaders, Central Coast Alliance, primary care physicians and others met on a beautiful Saturday to discuss where the problems lie and what the priorities should be. It was an inspiring exercise of caring for a population who are among the most affected by challenges in the healthcare system and the economy. There was no talk of assigning blame; only in understanding what the situation is in order that solutions may be found.

Key Points

1. The decision to build the CSP/PHF model, with 16 beds, was made with little to no other option available for funding treatment of Medi-Cal clients once Dominican decided to close its psychiatric unit. Funding of an inpatient unit required that services be eligible for Medi-cal reimbursement. The County based decisions using the average daily census which was 14.2 patients during the 3 years prior to Dominican closing.

2. This has had significant effect on the community's capacity for inpatient services, which at 16 beds is well below the average number of crisis beds per 100,000 residents in the state and drastically fewer than is recommended by Treatment Advocacy Inc., a national advocacy organization.

3. There are limited programs with 24 hour treatment beds for out-patient care in the continuum of care for those with significant mental illness / chronically impaired and who are at risk otherwise for repeated hospitalizations.

4. For privately insured patients and those with Medi-Cal but who are not seriously mentally ill, the system has significant challenges in accommodating their needs due to contracting and space issues.

5. This is not unique to Santa Cruz but is a statewide problem.

The California Healthcare Foundation in 2013 noted the impacts on the county-controlled mental health system design in an investigative paper. A few of the above issues were called out in this report:

- As the most populous state, California ranked first in the US for total spending on public mental health services but 15th for per capita spending.
- State laws shape California's public mental health delivery structure, but nearly all financial and administrative responsibility for delivering these services rests on counties. This decentralization has resulted in wide variation in program operations, quality, and service availability.
- As in many other states, funding for California's public mental health system is "carved out," or disconnected, from the rest of public health care system funding. As a result, people with mental health needs often must navigate two systems for care.

From: *A Complex Case: Public Mental Health Delivery and Financing in California* --- CHCF July 2013

It is of interest for us as advocates to learn and support changes that would improve the system of mental health and addiction care for all Californians, and that services would be received regardless of which insurance plan is involved. A re-thinking of the system design/decentralized control may be in order. We support all efforts that Santa Cruz County takes to mitigate the consequences of the mental health system as it stands, through collaboration and the shared ideas of all community agencies dedicated to this cause.

Family Engagement in the CSP Process

Counties throughout the state are investing in front-line services that are designed to prevent hospitalizations when possible. This least restrictive approach, however, does not work for everyone. This has drawn our concern, in cases where patients are released and the families have been unclear to why or what treatment their family members can access to stabilize their severe symptoms and illness. Families have been frustrated when the background information and history they wish to explain has not been included and considered in the assessment processes, and the individual is not accepted for treatment. It is usually a very traumatic time that leads a family/friend to attempt hospitalization of their loved one. Family/friends also need information, support, and meetings with doctors and social workers. Only extreme circumstances bring about these efforts to get care for family members.

Through the process of meeting with Telecare and county mental health leadership, there was much discussion on how to improve the communication with families while maintaining the patient's right to confidentiality. Several ideas have taken form and some specific changes were collaboratively developed in what has been a very positive approach between the county mental health team,

Telecare, and NAMI representatives. Carol Williamson, Sheryl Lee and Betsy Clark from the NAMI board have toured and worked closely with the new leadership, to improve awareness of the process for assessment and the potential impact on families. New training, processes, forms and signage have been or are in the process of being implemented to reflect a re-prioritization of the importance of family engagement and information in the evaluation period. NAMI is pleased that all parties recognized the importance of this role and anticipates improvement. It was another reflection of the desire of all parties to improve the service component of care.

Needed Care vs. Inadequate Bed Availability

Some individuals need hospitalization to manage and stabilize their serious mental health condition when it is in an acute phase. The prevalent conception that hospitalizations should be avoided carries the risk that patients who require that level of care will not be considered for admission when it is the best available, clinically appropriate level of care. This is done with all good intentions, and the patient may even seemingly be improved while in the Crisis Stabilization Program 24 hour evaluation period. However, a patient admitted to a crisis stabilization unit does not mean that the condition can be resolved within 24 hours. This was especially concerning because of the Sean Arlt case from October 2016. It is not possible to stabilize all patients within a narrow time window, and there are many reasons why a hospital admission would be the right decision. Crisis Stabilization should be reserved for those patients whose condition needs a more thorough evaluation to determine acuity, and whose symptoms indicate that they can realistically improve enough to be released within 24 hours. Other more seriously symptomatic patients should be quickly admitted to the PHF or to another hospital if beds are full. NAMI is recommending that strong relationships with regional psychiatric hospitals be established, providing placement support and assistance when patients are sent there from the CSP, to avoid treatment delay and help ensure a high standard of care is in place.

Less bed availability in communities impacts how services are provided. The average number of psychiatric beds in California is approximately 14/100K population, a figure far below the Treatment Advocacy Center's recommendation of 50 beds/100K. But in Santa Cruz County the ratio of psychiatric acute beds is now 6/100K, less than half an already low statewide average. This isn't because of a lower need level. Mitigation for this impact must be made in ways that do not result in the denial of patient admissions or the premature release of patients, when those patients need additional treatment to successfully return to the community.

Meetings with NAMI, County, Telecare

The NAMI task force on acute crisis services held several discussions on the best path forward to engage both the County of Santa Cruz and the Telecare Corporation. Two meetings included members of the county Board of Supervisors, and another with the mayor of Santa Cruz. We felt there was good support for these efforts, which were to be focused on a purely advocacy agenda.
It was evident that there were significant challenges in the CSP, beginning with leadership. The facility administrator position was vacant, as were other key leadership positions, including the Director of the CSP and the Director of Nursing. The Senior Vice President for Acute Services at Telecare was serving as the acting administrator of the facility. From the reports of family members, many of the staff were not receptive to the input of family members during the evaluation process, were unfamiliar with the

Family Information Form, and appeared to be without training in communication skills. We determined that there were not enough seating loungers for patients during high volumes, and that there was a lack of consistency in feeding patients, as well as no table for eating. There was no place to sleep, except the lounge chairs, though patients may have to stay even a couple of days in the CSP if there are no beds in the neighboring PHF. A shower facility was needed.

As noted in the introduction to this paper, NAMI President Carol Williamson reached out and found a warm reception and an invitation to meet from Telecare CEO Anne Bakar.

Telecare administration was attentive and concerned. Over the following few months Telecare gradually added on new leaders for the facility and the region who were reflective of Telecare's assertion that the organization is mission-driven for quality of care. A remodel with a shower was put in place. It has been obvious to the NAMI board members who toured the facility and spoke with staff, that a cultural change was very much needed in the facility and that such a change was undertaken through the leadership of Jesse Tamplen, MSW, LCSW, MHA, FACHE, an experienced clinical and administrative healthcare and mental healthcare leader in the state over many years. The staff reported to NAMI members on walk-throughs that they were receiving education and support in ways that they never had previously. There was a shift in focus to the quality of care and the importance of professionalism in all communication, with Mr. Tamplen himself modeling the way by personally evaluating patients and assisting families.

Telecare Contract

In the ensuing meetings, important issues of clinical and administrative policies remained even as other issues were taken off the table because of coming to satisfactory results. We've determined that the County's contract with Telecare represents a mostly capitated (fixed reimbursement) agreement. It is a true partnership, and the County of Santa Cruz' support for improvements in the facility must be reflected in the negotiated agreement. NAMI requests that the County and Telecare negotiate agreements that allow implementation of these improvements in crisis care.

Providing Involuntary Care: A Right to be Treated

As noted earlier, the State has implemented a plan where the provision of inpatient services cannot be limited, but the funding to pay for those services is limited by federal, state and county budgets. The current system puts the financial risk for all care including inpatient care on the counties, who are charged with managing these funds and developing less expensive treatment options when possible. While we do not doubt the integrity of the leadership or clinicians, the incentives to find alternatives to hospitalization has a known risk of influencing policies and decisions. This risk is true of any managed care system. Santa Cruz County operates, under a federal waiver and developed by the State in its Medicaid plan, a mental health managed care plan for Medi-Cal recipients with moderate to severe mental health conditions.

Involuntary mental health treatment is a necessary service to our community. It has resulted in the savings of countless lives. Families discussing their experiences with NAMI report that their loved ones were released from the CSP while they remain in an acute crisis state. The standards for who should be hospitalized on an involuntary status will also inevitably be impacted by the shortage of beds for involuntary care in our community.

Assessments and Evaluations for 5150

The NAMI Task Force reviewed the County's Training Manual for establishing criteria for 5150 detention holds, which is the manual used to train all people who can write a hold, including law enforcement. NAMI has expressed concerns with wording and has requested that The County include NAMI as participants in a thorough review and rewrite. The County has welcomed NAMI to participate.

The complaints received by NAMI from families in our community are not about their child or family member being admitted against their will, unnecessarily. Our complaints are the opposite – about individuals who are not hospitalized at all or released before being stable, when sometimes very ill, scary to their families and even to themselves; that they are released at times without the capacity or insight to attend an outpatient program, (which may not even be available to their level of need). Access to 24 hour residential capacity is very limited as an aftercare option.

CSP Evaluation Staff and Physician Roles

The most important decision in the Crisis Stabilization Program is whether a patient brought to the facility is detained for crisis stabilization or admission, or is released. This crucial decision is the most important purpose of the CSP, which has a psychiatrist on-call 24 hours a day.

Our community has learned how important this decision can be.

Sean Arlt, a young father who lived with a mental illness, died on a very stormy night of October 16, 2016, from gunshot by a Santa Cruz Police Officer. Our understanding is that the police had been called again, because he was in a delusional state of psychosis, with aggressive behaviors very similar to behaviors that had just five days earlier led him to be contained by multiple police officers under a 5150 and taken to the Behavioral Health Center.
Unfortunately, in that first incident, he was released within eight hours, before stabilized. Five days later, the second incident of October 16th, he had a confrontation with law enforcement that tragically led to his death.

Mr. Arlt's death had a major impact on the community and helped to spark this Task Force review of services at the CSP. Other families reported problems with assessments, and with quick releases.

There were discussions, in formal meetings and separately, between Telecare administration and NAMI regarding the qualifications and requirements of staff evaluating patients in the CSP, and the role of the psychiatrist in this process.

Telecare, with a new local administration in place, has upgraded its standards for releases from the CSP facility. Telecare will now provide a level of service above what is minimally required, and in keeping with the higher regional standards. Prior to release of an involuntary patient from the CSP following evaluation, a psychiatrist will be consulted for a review of the case and will provide advisement based on what he or she has learned. This is not an assessment by the psychiatrist, but given the volume of patients seen at the CSP, it would not be a standard in any known community of this size to have a psychiatrist available in person at all times. Individuals should not be kept in the facility if they do not meet criteria following an assessment by a mental health professional, but given the seriousness of this decision; we appreciate very much this change in practice and commend the leadership of Telecare for this willingness to listen and to act on our concerns. The bottom line is we want our community members to be safe and have access to treatment.

We remain concerned about the use of master's prepared "waived[2,3] staff evaluation of patients presenting to the CSP, unless they are additional to the primary licensed evaluator. We understand Telecare has recently increased pay for Social Workers in order to improve recruitment.

Accreditation and Standards for the CSP

The CSP and PHF are accredited by two bodies that oversee quality of care: CARF and the Joint Commission. The Joint Commission is a hospital oriented quality body and CARF is for mental health and SUD treatment and rehabilitation. Compared to hospital-based programs the regulations are lean. The State does not require either of these certifications and it is positive the Telecare and the county support this work to stay up to standards in the field. For continuity of treatment, NAMI advocates for

[2] *"Waived" staff means that they are qualified mental health professionals, not yet licensed, who are typically gaining working hours for their license and who may perform a great many of the responsibilities that licensed staff perform, under supervision by a licensed staff. Such supervision consists of weekly meetings.*

the Joint Commission to evaluate and credential both the outpatient CSP and the inpatient PHF. This would help the programs be more integrated and seamless.

A Greater Need for Alternative and Transitional Services

NAMI has identified that the availability of alternatives to hospitalization are limited and that more programs are needed. Patients with severe conditions need time for psychiatric crisis recovery, for medications to be adjusted and evaluated as needed, and for a fuller understanding of their needs to ensure continued recovery (especially young people with first break psychosis.) The whole experience as described by families is traumatic.

Current Alternative and Transitional Services

Telos Crisis Residential: A 10-bed unlocked facility with robust staffing, appropriate for diversion from hospitalization for certain individuals. Telos is a crucial resource for the CSP, to discharge individuals who do not meet the standard for inpatient care, or who are determined to be able to safely benefit from this level of outpatient care to resolve their crisis. Length of stay is currently from 10-30 days and is tightly managed in order to make room for new referrals. Many individuals could benefit from a longer stay in order to stabilize and be prepared for a less supervised setting or returning home. Another facility like Telos would be recommended for consideration.

El Dorado Transitional Residential: A 16-bed unlocked facility appropriate for individuals who are "stepping down" from an inpatient hospitalization. Residents participate in a variety of rehabilitative activities and County psychiatrists and staff work closely with residents as they continue to stabilize and move forward in their recovery. Length of stay is currently up to 30 days, longer in some cases. The contract allows for stays up to 90 days, but with great demand on beds, this length of stay is infrequent. As with Telos, many individuals would benefit from a longer stay to be better prepared for community living. Another facility like El Dorado would be recommended for consideration.

Second Story: An innovative, effective peer-operated residence for people in less psychiatric distress, which helps them head off a crisis, and avoid hospitalization. This program was created with a SAMHSA grant and recently has been able to purchase a house with a grant. Currently only 6 beds are available and length of stay is generally up to two weeks. More beds could definitely be helpful in the overall picture of crisis care.

There are other residential programs in the community with longer lengths of stay, but they are not the focus of this report. For example, Casa Pacific has a dual diagnosis focus and a longer length of stay. In addition, there are "board and care" homes and permanent supported housing beds, which have an indefinite length of stay. These programs are utilized for individuals who are in various degrees of stability, independence, and stages of recovery. They are definitely part of the overlapping system of care, and do affect the availability of the alternative and transitional programs, as people often move through many or even all of these programs, in their recovery process. (The River Street Homeless Shelter does have some temporary mental health beds, and it is sometimes, sadly, the only option for outpatient after-care from hospitalization, when other places are full.)

Santa Cruz County Mental Health and their contractors have done an excellent job in designing and implementing innovative and effective programs to minimize hospitalization rates and lengths of stay. This not only saves money, it can also provide a less traumatic experience for many individuals in a crisis or pre-crisis stage. The problem is that all of these programs are highly impacted, with waiting lists or lack of availability. When individuals are moving through a crisis, the right level of intervention and care at the right time is crucial to prevent further distress and outcomes like homelessness and multiple hospitalizations. We are in a situation where families often discover that the right level of care can simply not be accessed at the time it is needed.

Increasing the availability of alternative and transitional programs is an essential part of relieving the pressure on the Behavioral Health Unit and also in improving the quality and responsiveness of the crisis care system in the community.

Law enforcement and Mental Health

Local law enforcement plays an important and key role in the management of Acute Mental Health Crisis is. They are active participants in assisting our families, and have shared that they experience similar difficulties with shortage of crisis services, lack of beds, etc.

Due to litigation regarding recent cases, and other constraints that we have, we have determined that this is not the time for NAMI to address protocols and procedures. We request an opportunity to work with local law enforcement and mental health services regarding law enforcement and mental health protocols and procedures at a future time.

NAMI recently has worked with Santa Cruz County Mental Health, Santa Cruz Police Department and the Sheriff's Office to develop crisis intervention training for law enforcement officers to better respond to individuals in crisis. This has been very successful and is opening up important communication between NAMI and law enforcement. A police lieutenant has joined our board which helps with communication and understanding.

Hospital Emergency Departments and the CSP

NAMI reviewed concerns expressed by families based on their experiences following their loved one via the Emergency Departments or Medical Floor of regional hospitals to the CSP. NAMI interviewed clinicians on both the Emergency Department and CSP sides, and have determined that the process of care is problematic at times and could be much improved with some changes. The good news is that at the time of this report, discussions are ongoing with the county, Telecare and Dominican Hospital to provide improvement in some key areas:

1. Wait time for transfer to CSP following medical clearance by the Emergency Department.
2. Lab Studies not done in Emergency Department prior to transfer to Telecare, or capability at Telecare for this or more thorough lab work at ED prior to transfer.

3. Patients / Families spending long hours waiting transfer from the Emergency Department for assessment at the CSP.
4. Unpredictable flow of patients to the CSP with limitation of staffing levels and complexity of patients.

NAMI would like to see the administrations of the Emergency Departments, Telecare, and the county to meet and resolve these issues as soon as possible.

Staffing and Capacity in the Crisis Stabilization Program

The inclusion of both youth and adults at the same site, albeit in separate areas, presents a major challenge when both populations are present under the current staffing plan of the CSP (our understanding is that that plan is based on only adults being present). Because the ratio of licensed staff to patients is built without regard to age, capacity to provide evaluations will break down when children are present. When youth are being assessed, it is a much lengthier process than for adults and they are housed by necessity in a separate area of the building. Given this information, and uncertainty on how many patients can be held in the CSP, staffing planning is challenging, solutions are needed.

There is no capacity in our county for youth hospitalization; if youth are determined to need hospitalization, they are sent out of the county. However, they can be assessed at the CSP.

NAMI supports a better solution for youth crisis services and looks forward to hearing more about the county's goals for a separate outpatient treatment and evaluation service on the Telecare campus which would provide a more youth oriented environment and focus, and/or other plans.

NAMI Recommendations

1. The County of Santa Cruz and Telecare Administration should support the newly hired, experienced leadership at the CSP with the resources that they determine necessary for the improvement of care, including staffing allocations.
2. Recommend further advanced training for the mental health professionals designated for the evaluation of involuntary detainment, including training in suicide risk assessment. Recommend that an experienced licensed (rather than "waived") professional consistently perform the intake crisis assessment.
3. Ensure that staff evaluating the patient reviews the 5150/5585 form to determine if police are requesting notification for potential charges, prior to the patient being released.
4. The county to engage NAMI as a key stakeholder in updating the LPS/5150 training manual for the application and evaluation for involuntary detainment and explore options for those not meeting criteria for a 5150 hold.
5. Standardize best practice to improve staff interactions with families and patients. Consistently use the AB1424 Family Information Form as indicated in state law. Prioritize continued education on family engagement with staff and active feedback from NAMI.
6. Provide to family, as approved by the patient, an aftercare plan inclusive of medication information, follow-up services at the time of release, and educational materials applicable to the diagnosis.
7. Provide, with patient consent, information to the family regarding the decision about the level of care, and document such in the medical record.
8. County to provide CSP patients with face-to-face or telephone introduction when possible for follow-up county services recommended on discharge.
9. Recommend a change in accreditation vendor in the CSP from CARF to the Joint Commission.
10. County should explore increasing crisis residential resources and other 24 hour transitional residential treatment similar to Telos, (only 10 beds) with strong staffing support, to decrease discharges to unstable living situations or homelessness.
11. Working with CSPs across California, with input from consumers and families, identify and implement best-practice standards.
12. Implement changes in the medical clearance process and lab testing process to avoid unnecessary and redundant trips to the Emergency Department.
13. Evaluate capacity of the CSP to be determined along with a diversion plan or extra capacity that ensures the patient safety and improved service model.
14. Continue efforts to reduce staff turnover in the CSP and PHF, through improvement in wage scales, training, and improvement in the culture of care.
15. Empower nursing and social work/therapists through competitive wage scales, autonomy / leadership opportunity. Encourage and reimburse for specialty certifications.
16. Foster leadership stability and engagement and inclusion of key Telecare staff in system of care discussions with Santa Cruz County.

Dedicated to the memory of Sean Arlt and Keida Johnson.