2008 Report to the El Dorado County Board of Supervisors

By the El Dorado County Mental Health Commission

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EL DORADO MENTAL HEALTH COMISSION
REPORT TO THE BOARD OF SUPERVISORS 2008
Jeffrey Meyer, Chairman
BEHAVIORAL HEALTH COURT

The Behavioral Health Court was instituted to address the problem of mentally ill defendants in our criminal justice system. The BHC looks carefully at the nexus between the mental illness and the behavior that led to the arrest. The court has a team approach and supports clients who would be better served by treatment than incarcerated. In the establishment of a Behavioral Health Court, El Dorado County is part of a nationwide trend.

1. **BEHAVIORAL HEALTH COURT STAKEHOLDERS**
    - Consist of the judge, law enforcement, District Attorney, Public Defender, Probation, Drug and Alcohol, Mental Health, and a Patient Rights Advocate.
    - Communication and the sharing of divergent viewpoints and philosophies are essential given the different perspectives and interests of the stakeholder roles.
    - There is a general consensus among the stakeholders that progress is being made and that there is a commitment to the success of the program. The BHC in South Lake Tahoe reports an 85% reduction in recidivism for those clients completing the program.
    - Training for all members is necessary to promote awareness and understanding.
    - Family training and involvement should be encouraged to provide ongoing and long-term support of gains made through the BHC program.

2. **BEHAVIORAL HEALTH COURT CLIENTS; NEEDS AND RIGHTS**
    - Allowances must be made for the complexities of mental illness and the lack of insight that often accompanies the illness and the reality that many clients have concurring substance abuse problems complicating their treatment.
    - Treatment plans need to fit the individual and include access to intensive case management, counseling, medication, professional medical staff, and housing.
    - Housing options need to be made available depending on the needs of the client. Residential housing with high security and professional, clinically trained mental health staff is necessary to provide security for both the client and the public in the initial phases of the treatment plan. As the clients progress, less restrictive housing options should be available so that the client can be supported and make the transition to being a functioning, productive member of society.
    - The Patient Rights Advocate is an important part of the team, facilitating client and family's understanding of the legal and probation issues as well

as the treatment plan. An area to meet with clients and families confidentially should be provided.

EL DORADO COUNTY MENTAL HEALTH COMMISSION
REPORT TO THE BOARD OF SUPERVISORS, 2008
BEHAVIORAL HEALTH COURT PROGRAM
JEFFREY MEYER, CHAIRMAN

PURPOSE OF THE BEHAVIORAL HEALTH COURT PROGRAM

The El Dorado County Behavioral Health Court is designed to promote public safety and contribute to a reduction in jail recidivism and substance abuse among mentally ill offenders. This is accomplished by improving the mental health of incarcerated offenders through their enhanced linkage to post-release mental health and community services ordered by the BHC Judge. It is an intensive program designed to evaluate, treat and monitor participants, and provide coordinated and comprehensive mental health treatment, substance abuse treatment, and ancillary services to the participants.

GOALS

- Fewer days spent in custody
- Fewer repeat offenders
- Increase # of days in school, work, workability or involvement in mental health groups and programs

The El Dorado County Behavioral Health Court Program draws on the expertise and cooperation of the El Dorado County Superior Court; the El Dorado County Offices of the District Attorney and Public Defender, the Sheriff's Office; the Departments of Mental Health, Probation, Juvenile Treatment Center, local advocacy and support agencies, private providers of mental health services, substance abuse programs and ancillary services.

Behavioral Health Court is another element of the collaborative, problem-solving court movement and is seen as a promising approach in bringing stability, sobriety and safety to mentally ill offenders while ensuring the security and well-being of the entire community.

The Mental Health Commission finds that there is a consensus among the BHC program departments and team that this is a valuable program. All are committed to the goal of recovery and public safety. Sheriff Neves states that the Behavioral Health Court Program in South Lake Tahoe has a high success rate, and that the West Slope Program, which has not been operating as long as South Lake Tahoe will be equally successful.

Essential to the success of the BHC Program is provision of appropriate, professionally staffed housing and wrap-around services which will help a person with mental illness

become a functioning, productive member of the community, reduce recidivism in the criminal justice system, and increase public safety, which is the stated goal.

We want to thank all Departments which make up the Behavioral Health Court Program for helping to bring this highly beneficial program to our community.

EL DORADO COUNTY BEHAVIORAL COURT
INTERVIEW WITH JUDGE WAGONER
BILL CLARK AND JODIE JENSEN, DISTRICT ATTORNEY OFFICE
11/09/07

Larry E. Beutler, PhD. conducted the interview with Ms. Jodie Jensen and Mr. Bill Clark of the El Dorado County District Attorney's office on November 9, 2007, with an additional interview on November 15 with Judge Wagoner, who is the judicial authority over the Western Slope's Behavioral Health Court (BHC) program. These interviews focused on the current and future directions of the BHC.

Individuals guilty of committing a crime thought to be directly connected to the existence of a mental illness are referred to the BHC by their attorney, the public defender or another Superior Court Judge. Following behavioral assessments and determination of eligibility, they may become BHC "clients" or referred to another Superior Court department for sentencing. If accepted into the BHC program, these clients' probation orders take the form of mental health treatment plans that are designed to address the underlying behavioral problems associated with the crime they committed. Often, these clients carry a secondary drug dependence diagnosis along with the primary mental illness diagnosis.

Mentally ill BHC clients are referred to one of a variety of treatment resources in the El Dorado County mental health system. However, those with co-morbid mental illness and drug abuse problems (i.e., "dual diagnosis clients") have more limited treatment options. The Mental Health Department has contracted with the GATES program for transitional housing and a dual diagnosis caseworker. This (GATES) is the only Mental Health Department-contracted drug abuse treatment program available to dually diagnosed BHC clients. The GATES program is operated as on a RECOVERY model and as such, emphasizes the use of peer mentors and patient-counselors, with back up support from professional staff. Professional staff are not assigned to some of the GATES programs in this treatment model.

Judge Wagoner reports that, to date, there have been 11 people referred to and evaluated by the West Slope Behavioral Health Court program. He noted two significant successes among the clients assigned to either the mental health or drug abuse treatment programs. He expressed optimism about the future of the BHC program and clearly feels strongly that it offers a novel and effective way of addressing many of the problems of offenders with significant behavioral health problems.

An incident occurred in October, 2007 that is presently under a criminal investigation and will be reviewed by the Mental Health Commission upon completion.

Findings

1. An inherent conflict exists between the objectives and the values of those in the mental health system and those in the judicial and other public safety areas. Ms. Jensen and Mr. Clark point to this conflict as one of the factors in the initial stages of the program, but that a consensus and common goal is in place. Steps are being taken to introduce changes and more options.
2. The recovery-based treatment model may be inadequate to address medical and behavioral emergencies. In the case of emergencies, when events are unfolding rapidly, professional staff would be better prepared and more experienced than the non-professional, peer counselor and mentors utilized by GATES to recognize and respond to emergent demands.
3. The levels of structure and client monitoring required for success in the BHC program may be greater than those previously in place at the GATES program. While most mental health programs maintain a basic professional staff to support a 24/7 emergency response, the GATES transitional houses lack this level of staffing. Random drug tests, bed checks, individual drug counseling and monitoring of visitors (i.e., activities that are commonly incorporated into programs for drug offenders) are not in use at the transitional houses, they are provided at the residential treatment facility.

Recommendations:

Based on the suggestions provided by those interviewed, I recommend addressing three basic areas of concern within the BHC program.

1. Steps must be taken to bridge the differences in roles, methods and expectations/goals held by the various stakeholders in the BHC program.

There are at least three types of stakeholders, each with their own set of expectations, roles, values and interventions for how treatment and crises should be addressed. These include Public Safety (Judiciary, D.A., Probation), Patient Advocates (Public Defender, Patient Rights Advocate/Ombudsman) and Health Care Professionals (mental health staff, GATES program administrators and staff, medical providers).

Public Safety personnel are first and foremost officers of the court; they are concerned with adherence to law and secondarily with preventing and minimizing danger to the public. They are attuned to those events that increase the potential for spreading discord and endangering others. As a means of intervention, they emphasize the role of authority in preventing and controlling crises.

Patient Advocates, in contrast, are concerned with the needs and protection of

individual patients under their care. They work to enhance patient choice by providing them with information to help them make decisions in their best interest. They utilize methods of persuasion to encourage patient/offender compliance. Their preferred methods include informing those under their charge of their rights, educating them to the services that are available, helping them access those services, encouraging them to take advantage of the services provided, and helping them evaluate the consequences of their decisions. The goals of those who are patient advocates are to ensure that patient offenders' rights are protected and that the disadvantaged or disenfranchised are represented in the legal and social service systems.

Health care professionals are most similar to patient advocates in their values and goals, all of which emphasize patient empowerment rather than authoritative control. They identify closely with individual patient medical, emotional, and social needs. However, their methods of intervention are more easily identified with "treatment" of discrete behavioral or medical problems than with providing information and offering persuasion. While they provide information, as patient advocates do, health care providers see their larger role as dispensing various behavioral and medical interventions and relieving suffering or curing disease. Thus, they are interested in the causes and control of behavioral disorders that affect the individual, beyond simply the social consequences of behavior. Among the causes of behavioral and addictive disorders that are sought, however, health care specialists are also concerned with protecting patients from abuse, conflict, and threat from others and from their own impulses.

The key to resolving the differences among these three groups is ensuring that all participants understand the multiple roles and methods represented among them. Two methods are traditionally used for these purposes: 1) regularly scheduled opportunities to discuss these issues and to explore potential areas of conflict and 2) the establishment of an administrative team structure and associated guidelines that define the lines of authority and detail the procedures and roles to be assumed by all when crises occur.

Central to this process is the need to achieve a group commitment to a common set of objectives. Common expectations are most likely to arise from gaining a common understanding of the nature and goals of the intervention program. Here, a moderated discussion of the program objectives and aims might be helpful. A group facilitator may be able to initiate small group exercises that could result in a common set of expectations about the process and outcomes to be achieved by this program. Such a group would beneficially provide an opportunity to share and educate one another informally and formally about the hopes and aspirations held for the program and could complement the structured system of communication to be established around methods and roles.

An articulated set of guidelines also is needed to ensure that the methods used are understood and accepted by all members of the team. An orderly procedure can be

derived in part from group discussion, but an administrative oversight body must be responsible for creating lines of authority and a method for integrating personnel at multiple levels. Such a procedure begins with the development of an administrative structure and then is followed by educational training meetings of team members to enact, discuss and problem solve methods of addressing anticipated problems.

2. Treatment programs for mentally ill and drug abusing offenders should maintain an adequate staff to monitor program compliance, individual progress, and threats to the safety of clients at all times that they are in the program.

The existing transitional housing, based on the recovery model with the honor system lacks the security needed for clients being released from the jail. The program needs to establish, or staff, high security housing with professional, clinically trained staff. As clients progress in the treatment program they may level into a more transitional living situation.

There are options in the county, expansion of the psychiatric health facility, the GATES residential facility, or contracting with local hospitals who maintain secure psychiatric or drug abuse wards. The most advantageous would be for GATES to contract for higher security for safety of clients. Dual diagnosis professional should be involved in the treatment team.

3. A concerted effort should be initiated to ensure that all three groups of stakeholders are involved in developing and carrying out the "Public Safety" mission of the BHC program.

Developing an integrated administrative structure and enhancing communications around the mental health and drug abuse aspects of the program, it is equally important that all stakeholders also address the multiple missions of the program, including both the role of Public Safety and the role of personal empowerment and choice. For example, in order to ensure the success of the Public Safety mission, it will be important to ensure that the administrative group and the guidelines for addressing problems in the program are as devoted to Public Safety issues as to treatment issues. Likewise, it will be important that Public Safety personnel learn the procedures and objectives related to increasing patient self-direction and empowerment.

Once again, a NIMS-like system may be adapted to use at the county level to facilitate collaboration, cooperation, and integration of resources and personnel as needed in times of unexpected difficulty.

Larry E. Beutler, PhD
El Dorado County Mental Health Commission

EL DORADO COUNTY MENTAL HEALTH COMMISSION
INTERVIEW WITH GATES FOUNDATION
BEHAVIORAL HEALTH COURT PROGRAM
TOUR OF TRANSITIONAL HOUSE ON SPRING STREET
AND DETOX/RESIDENTIAL FACILITY
November 27, 2007

Reviewed By: Bonnie McLane and Cathy Hartrum
Interview with: Pete Nielsen, Program Manager
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The County Mental Health Department contracted with GATES for 24 beds. There are two transitional houses; one for men on Spring St. in Placerville, the other is for women, in Cedar Grove. The Spring Street house is staffed by a live in peer who has been clean and sober for at least one year. The house is operated on an honor system. The clients are 'locked out' of the facility for a period of time during the day. Staff from the mental health department transport clients to the Prospect Place Program for day activities. Clients, otherwise, are free to come and go. Clients share cooking and cleaning, medication is under triple lock and clients take medication under supervision of staff that comes from GATES. Staff meets state requirements for a transitional house.

There is a philosophical difference in treatment of a person with substance abuse and a person with a mental illness. Even though a client may have a mental illness, staff feels that there is still accountability, self-direction, and independence to a certain level. The object of treating substance abuse is one of restoring empowerment, accountability, the will to change a destructive habit, and understanding of consequences. Boundaries and appropriate consequences work well.

On the other hand, a person with a mental illness can often lack insight, are unaware or limited in understanding of consequences. Day to day living situations can be difficult. Often with appropriate medication and supportive living situations they have the ability to function at higher levels. GATES believes that a person with a mental illness must be encouraged to attain a higher level of functioning, and believes there can be continued improvement with proper treatment. The GATES Program seems to have a knowledge, compassion, and desire to maintain a high standard and success rate with their substance abuse clients as well as people with a mental illness.

This review team finds that it may be a difficult task to find counselors specializing in dual MH and Drug Abuse diagnosis who have the wisdom to know when to set boundaries and when to be supportive, but it is essential to the success of the dually diagnosed clients. The review team finds that GATES is very aware of the differences in treatment and is capable of providing counselors and staff to meet these needs. Mental Health contracted with GATES for a case manager to oversee the dual diagnosis day program only. This counselor does not interact with clients at the GATES transitional houses.

INSPECTION OF THE GATES FOUNDATION DETOX/RESIDENTIAL FACILITY
November 27, 2007

This is a residential medically managed facility with 9 beds. It provides detox and residential living. Detox has a step up program as client progresses. The facility is licensed by the state for Community Accreditation Rehabilitation Facility. They are certified by the American Society of Addiction at the highest level of service. They work closely with state boards and provide mandated training, with a multitude of in-house training.

GATES certify staff to higher levels with completion of particular trainings and testing, above training required by the State. They maintain a staff ratio of 3 to 9, one of the staff during day light hours being a medical director. Nighttime ratio is 1 to 9 with a supervisor on call. All ancillary staff goes through, at least one detox training.

Medication is blister packed by the pharmacy and the client takes medication under the direction of Staff. There is a double lock to the medication and three journals kept of activities and medication, redundancy record keeping is done as a checks and balance. The office has a new Automatic External Defibrillators.

Detox clients are given a physical and blood work done within 24 hours to determine health and need of prescribed medication. Residential clients see a doctor as needed. Random drug testing is done.

Facility is coed with men in one room, women in one room. Clean spacious rooms. The facility is not a locked facility, but staff is notified when an exterior door opens. Clients are permitted outside to exercise and smoke. The detox program is usually 15 days or until stable. The residential program is 30-60 days, depending on individual needs. The program provides drug and alcohol groups, education, and treatment plans.

Clients may have family as visitors, but family must participate in the recovery program. Substance abuse creates maladaptive behavior within the family, recovery is a family goal. Staff relies on empowerment and accountability. The program uses a clinical, medical, and social approach to recovery.

Recommendations:

The Detox/Residential Facility is recommended for clients of the Behavioral Health Court Program who are leaving jail and just beginning treatment. This will ensure that the mentally ill person is stable on medications, and is in complete understanding of the treatment plan. It will also ensure that they have been detoxed appropriately and substance abuse issues are defined and understood.

As the Gates Program Manager stated in our interview, they are in favor of family involvement. They have in place for the detox/residential facility that before a family

member can visit; they must go through a training which is offered. It was stressed that family involvement can be very beneficial particularly when the client agrees to share information with the family concerning substance abuse behaviors, and other relevant information. In other words, to have all the cards on the table. We would agree that this is a critical role for the BHC Program.

The Spring Street house is a three story building, with steep stairways. We find that this might pose a risk to mentally ill individuals on psychiatric medications. We recommend that more appropriate housing be considered. There is also a balcony which could pose a risk to a person not yet stable on medications, who may have suicidal ideations not recognized by staff.

We recommend housing be provided in a stepped mode from hospitalization or incarceration to a staffed, licensed residential facility, with counselors specializing in dual diagnosis available. As the client progresses they could move to a lower level of monitoring, and eventually to transitional housing.

It is difficult to integrate services for dual diagnosis clients, you must include all departments, including law enforcement, and everyone needs to agree on the treatment plan. Treatment plan should follow the Dr. Mee Lee Model.

Gates has contracts for clients in the Behavioral Health Court and also for clients participating in the Prospect Place Program. This contract is for transitional housing only. We recommend that the Mental Health Department contract for beds at the Detox/Residential Facility. Staffing at Transitional Houses must be at a higher level for persons with mental illness than the traditional housing used for those with substance abuse.

EL DORADO COUNTY MENTAL HEALTH COMMISSION
INTERVIEW WITH SHERIFF JEFF NEVES & LT. PAM LANE, JAIL COMMANDER
BEHAVIORAL HEALTH COURT PROGRAM/WEST SLOPE
December 11, 2007

Reviewed by: Bonnie McLane and Cathy Hartrum

Sheriff Neves is in charge of over 400 employees. If mental illness is a catalyst for a criminal event, it is to everyone's advantage to have a person with mental illness referred to the Behavioral Health Court. It eliminates a burden on the system, his facility and staff, and it is better for the person involved and their family.

An individual's crime and the determination of mental illness are crucial to the screening process. There is a fine line law enforcement must maintain in meeting the needs of a person with mental illness, the protection of that person, and public safety. It is

imperative that a program is in place that will supervise and support a person who has a mental illness. Providing wrap-around services will help the person become a functioning, productive member of the community, as well as reduce recidivism in the criminal justice system, and increase public safety.

Judge Wagoner has emphasized the importance of the Behavioral Health Court Program, and the team has diligently worked to open lines of communication and provide wrap services to encompass the entire program. The Judge is the nucleus.

Sheriff Neves feels there is a consensus of the Behavioral Health Court Team that the Program will be successful. There is a learning process for each department. With different goals and responsibilities the team must work together to best bridge gaps that might occur while a client is on the road to recovery. As the structure of the team becomes stronger, more organized and structured, the percent of success will follow.

A comparison of South Lake Tahoe and the West Slope's Court Program was discussed. It was noted that South Lake Tahoe has a well-knit community. There is little turnover of staff, as compared to the West Slope and the Court Team are familiar with each other and familiar with clients and what will make them successful. There has been an 85% reduction in recidivism. The West Slope Program has not been operational as long as South Lake Tahoe, but there has been a lot of growth. There are a variety of communities with far outreaches including Georgetown, Somerset, and El Dorado Hills. This presents a challenge for law enforcement to have a pulse on the population as it is ever changing and expanding.

Either Lieutenant Lane or the Medical Officer attends all Behavioral Health Court Team meetings. Lieutenant Lane has arranged for an on-line form to be added to the EDCSO Website, 'Inmate Medication Form' which allows family members to provide medical information in a concise way to the jail medical staff.

Training is on-going and the Behavioral Health Court Team has plans to meet with Dr. Mee Lee in February to further enhance the program.

The Sheriff stated it was difficult for him to arrange for his West Slope staff to attend CIT 8-hour or 40-hour trainings. It entails overtime, keeping officers from duty, and trying to include everyone was a logistical problem. He felt the best way to brief front-line Deputies was by way of vignettes to the Officers, or Sergeants and passed on at staff meetings.

Post Traumatic Stress Syndrome has been noted. There are ex-military personnel in the workforce and in the community. Mental health services need to prepare for the rise in numbers in the community and plan for appropriate services. If there are internal issues in the department, those in charge rely heavily on the Chaplain Program.

If a community member has a complaint, they are directed to the grievance process. The Sheriff is very clear that there are no retributions and every complaint is reviewed and

given his highest attention. He is adamant that there be a high level of trust between the community and the department. The public is usually dealing with law enforcement under emotional conditions and each officer brings their own personalities and strengths to the job. It is a balancing act to maintain public confidence while providing the highest degree of safety to clients as well as society.

Lieutenant Lane expressed her approval of the California Forensic Medical Group who is in charge of the medical needs of the jail. She felt that they were responsive and met the needs of the clients. When she had questions or concerns CFMG was quick to remedy a situation.

EL DORADO COUNTY MENTAL HEALTH COMMISSION
INTERVIEW WITH EL DORADO COUNTY/WEST SLOPE PROBATION DEPARTMENT
KATHLEEN HENNINGS, PROBATION OFFICER, BEHAVIORAL HEALTH COURT TEAM
December 11, 2007

Interviewed by Bonnie McLane and Cathy Hartrum

Ms Hennings was an active participant in a Juvenile Behavioral Court in Santa Clara County for six years. She has extensive knowledge of the complexities of those with mental illness, as well as individuals who are dually diagnosed and in the criminal justice system.

Probation staff is in agreement that incarceration is not the place for a person with mental illness. Probation feels a good connection and cooperation is in place within the treatment team. There was a learning curve as the program was developed. There are roles and limitations for each department in the treatment team, but there is a common goal for the success of the program.

Probation attended a workshop presented by Dr. Mee Lee who is a board-certified psychiatrist. The focus was on skill building in engaging and helping people to change. The presentation addressed recovery in addiction as well as mental health. The emphasis was on how to increase skills in engaging the client as an active participant in their treatment and service plan. Ms. Hennings attended this presentation with other members of the Behavioral Health Court Team and likes this model of recovery.

The treatment team meets every two weeks, prior to the Behavioral Health Court sessions, to assess/review treatment plans. The commonality of substance abuse and mental illness is understood and is part of treatment planning. The treatment plan should be an active living treatment plan that may be modified to be able to meet the 'best needs' of the client.

The Team has initiated the position of mental health coordinator to attend medical appointments with clients so as to enable the Team to better assess the proper medication for health needs in addition to mental health needs. The program will also expand to include a psychiatrist as well. Peer support and mentoring can be an asset to the program, and discussions are underway to provide a peer advocate for clients.

Family members are included when appropriate, and on an individual basis. Family education which includes co-dependency issues can be a benefit.

There should be a variety of options for housing, job training, activities and support for the clients coming from incarceration into the community. There are many successful programs throughout the state, and rather than research and start from scratch, the county could utilize the advice of an experienced consultant to assist with the program.

Continued sensitivity and awareness of the needs of individuals with mental illness should be maintained. Intervention rather than incarceration is appropriate, however with the first priority being the safety of one's self and the safety of the public. Since its inception, the Probation Department sees more positive changes and options being brought to the Behavioral Health Court Program.

Recommendations:

Clients coming into the program, and especially those who are newly diagnosed should be provided more appropriate housing in a secure and licensed facility. Professional clinically trained staff is also recommended, ensuring that clients are stabilized on medications and progressing in treatment to address drug and alcohol addiction. After stabilization clients can be transitioned back into the community according to their needs and progress in the program. However close monitoring should continue as long as the client is in the program.

A peer advocate would be an asset to the program, however not as a member of the treatment team, but as a support to the client. This would provide an environment of trust in which concerns can be voiced freely. This would also ensure that the client understands the treatment plan as well as sanctions that may be imposed for non-compliance.

Family training and involvement when appropriate would further ensure complete understanding by the clients. Often a client presents well, and seems to understand clearly the program and treatment plans. Use of advocates would ensure that there is indeed complete understanding. Family member involvement can further enforce adherence to the program, and provide appropriate support, as well as critical information to the team of potential set backs with their family member. Family involvement however must be with the client's approval. Information provided to the team should first be reviewed with the Public Defender to ensure the appropriateness and that it is in the best interest of the client.

EL DORADO COUNTY MENTAL HEALTH COMMISSION
BEHAVIORAL HEALTH COURT PROGRAM/WEST SLOPE
INTERVIEW WITH LT. PAM LANE, JAIL COMMANDER AND
LISA ISAACSON, JAIL MEDICAL PROGRAM MANAGER OF CFMG
January 11, 2008

Interview by Bonnie McLane, EDC West Slope Chairperson
Cathy Hartrum, MHC Advisory

Lisa Isaacson, R.N. is the Jail Medical Program Manager for both the West Slope and the South Lake Tahoe Jail Facility. She is employed through California Forensic Medical Group. CFMG is the Contract Medical Provider for El Dorado County and in 20 other counties throughout California. She has oversight of the two jail facilities, and the two juvenile halls. Dr. Buche is the attending psychiatrist and does a teleconference visit with clients once a week. Dr. Buche communicates with the patients and directs the R.N. and Staff as to treatment and medication. CFMG uses a formulary for medication, but if an outside doctor orders a specific medication, those needs are addressed. Lieutenant Lane feels that CFMG personnel are very responsive.

Upon entering the facility the jail booking notifies the medical staff if someone presents as having a mental illness. The medical personnel does a medical evaluation. There is a thorough screening and verification of prescription drugs to ensure that they are current, and that the patient is actively in treatment. Once verified, the medications are continued. CFMG uses a formulary for medication and there are times a generic or like medication is used instead of the clients name brand. If an outside doctor orders a specific medication, those needs are addressed. Family information is a valuable tool in the initial assessment. The jail will begin use of an 'Inmate Medication Form" which will enable families to provide concise medication information to the jail medical staff. This form is available on the Sheriff Department's website. .

CFMG contracts with the Mental Health Department and a therapist is available 4 hours a week, or as needed in both jails. Lt. Lane has open communication with the Patient's Right Advocate. Treatment of a person with mental illness is important and every attempt is made for early identification. The increased population and transient culture remain an issue deputies are continuing to deal with.

There is an hourly physical check of all clients of the jail. If a person is suicidal, they are placed in a safe cell and checked every 15 minutes. If a person is ill they may complete a sick call slip and they will be seen and treated. Also the Rover Officer can notify jail medical of persons exhibiting signs of illness. If a person becomes psychotic, the Jail Medical Personnel are not licensed to do a 5150, involuntary hold, in order to force medication compliance. There is a MOU between the Sheriff's Department/Jail Facility and the Mental Health Department/PHF that a Deputy is assigned to transport the person to the Psychiatric Health Facility and remains on guard until the Psychiatrist assesses the person and gives approval for the Deputy to leave. However, Lt. Lane must give the final approval.

It becomes a complex issue with confidentiality as staff deals with the emotional needs of the client and family. Officers have the ability to take information, but often cannot give information to the family. The perception of the clients or family may not be complete because of the stress of the situation. Jail medical staff have in-place procedures, rules are followed; the record is clear and concise. Complaints through the proper channels are taken seriously. The Sheriff's Website has useful information to the general public. Jail Tours can be provided also to the general public.

Because of the structured environment, many clients follow a strict routine and improve medically while they are incarcerated. Upon release, clients many times do not have access to proper medical and psychiatric care. So while jail is an undesirable placement, sometimes the environment can actually enable a person to improve their general and psychiatric well-being.

The medical staff does not deal with the BHC directly but facilitates treatment of incarcerated persons under the supervision of the Behavioral Health Court Staff. Officer Mosely is on the BHC team and the liaison person. As data is collected, the R.N. would be interested in tracking clients as they progress on the road to recovery.

There is a consensus that the Behavioral Health Court continues to improve. There are improved communications between the team members, and staff is committed to the goal of recovery and public safety.

EL DORADO COUNTY MENTAL HEALTH COMMISSION
INTERVIEW WITH EL DORADO COUNTY MENTAL HEALTH DEPARTMENT
MEMBERS OF THE BEHAVIORAL HEALTH COURT TEAM
JANUARY 19, 2008

Reviewed By: Larry Beutler and Cathy Hartrum

Attending:		
	Deb McCartney, Program Manager	1/09/08
	Michelle Brintle, LMFT	1/09/08
	Janelle Gerber, MH Clinician	1/09/08
	Kim Severtson Brehm, MH Worker II, Case Manager	1/09/08
	Ken “Doc” Jones, Gates Detox Supervisor	1/09/08
	Christine Kondo-Lister, Deputy Director, EDCMH	1/16/08

Background

The current report is a continuation of the review of the Behavioral Health Court (BHC) which was initiated by the El Dorado County Mental Health Commission. This report is an annual review of status and progress of this program which has been operating for approximately a year. The current report should be considered in light of the previous interviews with individuals from the Judiciary, public safety, and adult probation and others that serve as members of the administrative team. In the current interviews, focus was upon the mental health and substance abuse treatment teams. The focus of these interviews was upon working relationships among members of the administrative and treatment teams, issues within the treatment team itself that may benefit or hinder effective treatment, and an assessment of the effectiveness of the program thus far. A review of patient charts was also undertaken to determine how well intake information is used to develop treatment plans and to monitor patient progress.

At the time of this writing, we did not have a complete accounting of how many individuals have been referred to the BHC and their dispositions. Ms Deborah McCartney agreed to provide the MH Commission with this information to include in the final report to the Board of Supervisors. This additional information is included in Appendix 1.

Working Relationships Between the Treatment and Administrative Team

There is general agreement that progress has been made in developing collegial relationships among those in the judiciary, law enforcement and public safety, mental health, and drug abuse program leaders and workers. All team members seem to be working closely with those in other disciplines and are committed to the success of this program. Nonetheless, it was also acknowledged that there have been problems with communication and coordination among the various working groups since the inception of the program on the West Slope, Fundamental changes have been and will be made to improve these working relationships.

Clearly, each stake holding group has a somewhat different interest in the program. Law

enforcement and probation emphasize the importance of public safety while mental health and substance abuse team members emphasize quality of life, self-direction, and personal growth of the offenders. Ways to encourage the sharing of divergent viewpoints are under consideration (see recommendations). The focus of these discussions is upon ways to create experiential learning experiences to better understand both the offender/patients and the perspectives of other stake holding groups who participate in various ways.

Working Relationships within the Treatment Team

Again, it was widely acknowledged that much growth has taken place to develop a cohesive treatment team. Members of the MH team, who have worked together for some time and who have a common perspective of the role of behavioral health treatment, work well together and often are in meetings together where their perspectives are shared and explored. More difficulty has arisen in incorporating the perspectives of the drug abuse treatment team with those of the mental health team. Like the mental health team, the drug abuse treatment team(s) are cohesive working group(s) and shares a common perspective on treatment. However, the perspectives of what is effective for mental health patients and what is optimally effective for drug abusing patients is sometimes at variance.

Dialogue between those in the MH system and those at the GATES program, which has adopted a drug abuse model, has become increasingly productive and many changes have been made in both systems to advance the working relationships. For example, in response to some expressed concerns by the Probation Department, mental health, and the Judiciary, random Drug Screening of participants is being done more frequently by Gates and Probation.

The remaining areas of discrepancy between GATES and mental health perspectives largely involve issues of staffing and staff training. Staff at the transitional houses traditionally are not being screened for legal background in compliance with some legal restrictions on employment that are applied to mental health populations. Areas of needed legal compliance are being explored and guidelines are being developed to address these areas of concern.

GATES acknowledges that more staffing should be provided for clients housed at transitional houses, both professional and non-professional. More clients are being housed now in the Gates Detox/Residential Facility, which is appropriate for persons just leaving the county jail, those not stable on meds, and who have not yet been in drug & alcohol treatment. The amount of time which a client can be housed at the Detox/Residential House can is approximately 30 days which allows more time for in depth assessment and to ensure the client is stable on medications. However, a longer period of time for some clients would be beneficial, depending on the progress made.

A review of several patient records suggest that there is a poor fit between patient incoming needs, status, and prognostic indicators and the level of treatment structure and

focus that is provided. Moreover, there is little done in a formal way to establish stable goals and monitor them over time.

The foregoing suggests a number of areas that served as the basis for our recommendations (see the following section of this report). These recommendations should not obscure the improvements that have been made to enhance patient care and staff coordination, however. For example, emergency Preparedness training has been implemented. Likewise, Mental Health Staff are now more involved with the client and Robinson's pharmacy to ensure medications are available without delays. The Mental Health Team is also now attending all medical appointments with clients.

Similarly, staff training also has been initiated to facilitate working relationships across disciplines of those in the treatment teams. For example, Dr. Mee Lee has been engaged to train the staff in the use of motivational interviewing techniques. These training programs have been well received and are scheduled to continue in February 08. This constitutes a positive step in strengthening the West Slope BHC Program

Appendix 1: Clients Entering the Behavioral Health Court Since its Inception

M/F	AGE	# OF MONTHS IN PROGRAM	HOUSING PROVIDED Y/N	SUPPORT SERVICES /MED SUPPORT	INCARCERATED SINCE IN PROGRAM	REASON FOR EXITING PROGRAM
F	33	2	N	Y	N	N/A
M	40	8	Y	Y	N	N/A
M	31	10	Y	Y	Y	N/A
M	31	6	N	Y	N	N/A
F	36	13	N	Y	N	N/A
M	28	8	N	Y	N	N/A
M	24	9	Y	Y	Y	VOP/OPTED TO SERVE JAIL SENTENCE
M	20	4	Y	Y	Y	VOP/REMANDED TO PRISON SENTENCE
M	25	5	N	Y	N	N/A
F	47	1	N	Y	N	N/A
M	25	2	Y	Y	N	N/A
F	20	4	Y	Y	Y	VOP/OPTED FOR SUMMARY PROBATION
F	24	4	Y	Y	Y	VOP/FOUND INELIGIBLE FOR BHC
M	24	2	Y	Y	N	N/A
M	45	1	N	Y	N	N/A
M	33	2	Y	Y	N	FOUND INELIGIBLE FOR BHC
M	45	ASSESMENT ONLY				
M	42	ASSESMENT ONLY				
M	33	ASSESMENT ONLY				
M	26	ASSESMENT ONLY				

Compiled by Debra G. McCartney 1/24/08

Summary:

- 20 clients have been referred to WS BHC since December 2006.
- 16 clients were determined to meet BHC criteria and participated in a minimum of one month of service.
- 4 clients were seen for assessment only and determined to **not** meet BHC criteria.
- The average participation period is 4 months.
- 56% of the clients received housing as a part of the program.
- 100% of the clients receive 10-30 hours per week of dual diagnosis group work, individual therapy, case management and medical support services.
- Nearly 70% have had no probation violations during their participation in the program.

5 clients have exited the program-1 was determined to not meet the criteria, 4 had violations of probation.

Recommendations

1. A Patient Right's Advocate would be an important addition to the team to ensure complete understanding of treatment planning and probation agreements. A Peer Advocate should be added to the team.

2. In that staff for the transitional houses is usually in D&A recovery for a year at the least, staffing should be provided by professionals with mental health background who have experience with dually diagnosed clients, to supplement the reliance on a non-professional staff person in recovery.

3. It is essential that all members of the team understand the different roles that each bring to the program. Cross training programs among law enforcement, judiciary, mental health, drug abuse, and the like would help promote this type of awareness.

4. The location and layout of the Spring Street transitional house was discussed regarding safety concerns. While this particular transitional house is adequate for the traditional use of T Houses, for the mentally ill, the steep stairways and balcony could be problematic for clients on psychiatric medications.

5. The addition of more family training and involvement is encouraged, as well as team building. Discussed collaborating with Mental Health, Nami and Gates for trainings for both family and staff would be helpful.

6. Finally, treatment needs to be more individualized and intensive. The Mental Health Department Team is working more closely with Psychiatrists but also needs to be more aware of effective criteria for making treatment decisions, identifying goals for each patient, and monitoring patient progress.

EL DORADO COUNTY MENTAL HEALTH COMMISSION
INTERVIEW WITH MARK RALPHS, PUBLIC DEFENDER
BEHAVIORAL HEALTH COURT PROGRAM, WEST SLOPE

Reviewed by Bonnie McLane and Cathy Hartrum

Mr. Ralphs serves as the Public Defender for those in the Behavioral Health Court Program. His perception is that the court program has been a success and he is assured the outcome will be less recidivism of individuals with mental illness being incarcerated. He states the program is in the early stages, but he believes the potential for success is high and there have already been very positive steps.

He has been in his position for almost 18 years and believes jail is no place for people who are mentally ill. They are often vulnerable with little chance for improvement without proper services. With the Behavioral Health Court Program there is a real chance for a person to function at a higher level in society. Mr. Ralphs emphasized the need for additional support and appropriate staffed housing as clients transition from incarceration to a residential facility, eventually to a transitional house.

A person has good intentions when incarcerated to sign an agreement and to do as they promise, but when released society can be intimidating and a handicap to a person with a mental illness if not offered appropriate housing and support. After release from incarceration, clients should be in a structured environment such as an in-patient residential setting with qualified staff until behavior and medication is stabilized. A client should step up to transitional housing as directed by certified staff and the Behavioral Health Court Team.

Recommendations:

The Behavioral Health Court team should include a representative from the Placerville Police Department, they incarcerate at the county jail, but many of those arrested are residents of the city.

The Patient's Rights Advocate or other advocate should be involved in the plea bargain process and signing of the agreement to enter the Behavioral Health Court Program, ensuring there is complete understanding of sanctions and consequences should a client violate probation. A peer advocate can also provide much needed support and understanding, as well as helping clients stay on track with their treatment plan. Family members should be included where appropriate to help clients understand their treatment plans, probation's expectations, and to offer support.

EL DORADO COUNTY MENTAL HEALTH COMMISSION
REVIEW OF THE PSYCHIATRIC HEALTH FACILITY, PLACERVILLE
September 19, 2007 - 10:00 am to 12:00 pm

MHC – PHF REVIEW TEAM

Larry Beutler, PhD.FAClinPsy Chair, Clay Dawson, and Bonnie McLane, did walk through, other members of team, Marbri Carroll and Denise Burke. Jeffrey Meyer performed the fiscal review.

FACILITY

Background

The Psychiatric Health Facility (PHF) is licensed as a residential facility (License #1015002) and is administered by Marlene Hensley, LCSW. Ms Hensley has been working at the facility for 12 years, as has Dr. Tran, the facility's in-house psychiatrist. The PHF has 15 beds and the average occupancy during the past 12 months has been 8.9 patients per day. The average length of stay is six (6) days.

The PHF was last reviewed by the California Department of Mental Health in March, 2007 with a report tendered in September of this year. They were granted full approval and judged to be in substantial compliance with state regulations (one criteria was indicated as being out of compliance because of behavioral order was not dated).

Procedures

Most admissions are through referral from a law enforcement officer and the patient is seen in a state of acute stress. Through cooperative agreements, the PHF will also evaluate and admit patients from Amador County, and if space permits, will receive transfers from other counties Mental Health Programs, as well. Because El Dorado County is between two popular destinations, Sacramento and Lake Tahoe, the PHF is able to offer services to people throughout the state and even from out of the country.

A Crisis Worker is on call at all times and is the initial contact with the prospective patient. The Crisis Worker reviews patient status, and assesses danger to self and others, depending on this assessment, within the first 24 hours, the patient may be transported to Marshall Medical Center or Barton Hospital for medical assessment and a review of compliance with criteria of Medical Necessity, the condition under which MediCal will reimburse the county for patient services. The medical evaluation usually consists of a review of physical symptoms and history, blood work, substance abuse evaluation, and mental status. Depending on the determination of Medical Necessity and the availability of alternative placements, the patient may subsequently be referred, discharged, or admitted to the PHF by an in house physician who is also on call.

Transportation of the patient to and from the hospital is undertaken either by law enforcement personnel, ambulance, or by the Crisis Worker in PHF's "cage car". Within the first 24 hours of admission, all patients undergo a History and Physical, which is conducted in the PHF if it was not completed in the hospital, previously. Collateral information is also obtained during this period and initial determinations are made about patient care. At this time, patients are also given a binder with documents describing "Patients Rights", authorization to release information, personal statistics, and a behavior contract. Grievance procedures are described for patients, as needed, by a patient advocate.

Within the first 72 hours, the patient undergoes a nursing evaluation and is the topic of an admission conference. Social status is also evaluated in this time frame and a discharge plan is initiated, consisting of identified goals and objectives. For extended stays beyond this point, the staff may petition for a 5250 admission for presenting danger to self and others, or for a 5270 determination of being gravely disabled. Occasionally, patients with special needs who do not meet criteria for Medical Necessity may be kept on the unit until alternative care can be arranged.

While in the PHF, patients are kept on medication that is needed for physical problems (i.e. high blood pressure, cholesterol, chronic conditions). They are admitted to a regular room unless they are self-destructive or agitated, in which case they are admitted to the observation area. Seclusion is also available for agitated patients. Each day, patient records are passed on at a shift change in writing and verbally.

A social worker is available to help identify and resolve family difficulties and to find appropriate living arrangements for patients. There is a Patients Rights Advocate that works with the patient, as well, to ensure that they understand treatment and that their wishes are represented in all court hearings and admission procedures. There are planned activities with the patients starting with a staff meeting each morning then conversing with each patient as to their individual plan, actions and goals to attain. There are exercise machines and arts and crafts in the afternoon. In the evening there is a wrap up meeting. There have been four unannounced visits by the state in a year, predicated on a grievance and there have been a small number of lawsuits against the facility for alleged inadequacies. These have been settled without adjudication.

Buildings and Ground

The PHF was initiated in El Dorado County in 1977 and moved to its present facility in 1982. The PHF is one of approximately 15 adult acute-psychiatric residential facilities in state licensed by DMH as a PHF and the one with the lowest annual budget and the second to lowest daily census. It is in an aging building but the facility is well kept and orderly. It has palatable colors, new carpet and paint, is clean and the administration has instituted wise used of every available area, which allows adequate space for amenities. The offices are adequate, the kitchen is small but necessities are handy and it is worker friendly. The PHF maintains responsibility for daily preparation of all meals for all of it patients. The Day room is large, has television, board games, and exercise equipment. A small outdoor area is security fenced and shaded. A computer Play Station is available to

younger patients but there are no computer facilities for patient use. Bathroom, shower area, and bedrooms have been state inspected and modified to prevent accidents or suicide. The observation room is modified with no sharp edges and is viewed directly from the nurse's station via closed circuit TV. The Seclusion Room is modified for safety of consumer and staff. The waiting room is small, has posting board with flyers from local organizations, flyers on grievance, procedure, Prospect Place, appeal process, and various community resources. The laundry room has new appliances and shelves with clothes for the use of incoming patients. The nurse's station has monitors over most of the facility. Nurses have a crises button they wear as they move within the facility in case of emergency.

Staff
At full capacity (N = 15), state regulations require availability of up to five (5) Mental Health Workers, five (5) Nursing Staff, and two (2) Licensed Mental Health Professionals over any 24 hour period. The availability of a psychiatrist, licensed clinical social worker (LCSW), and a clinical psychologist are also required (depending on census), though specific time commitments are not defined by the state. Since the facility is small and usually has fewer than 10 patients at any one time, they employ five full time Mental Health Professionals and Mental Health Workers. They have a post-doctoral clinical psychology trainee available to them and a full time psychiatrist who also handles 24-hour call. The PHF is usually able to maintain required levels of staffing if they supplement the full time staff by using temporary workers obtained through a registry service. While workable, this does not allow the facility to maintain the number of full time staff to meet the criteria necessary to service a full unit over extended periods of time. Marlene Hensley, Program Coordinator, utilizes pre-screened contract workers from the Registry to fill gaps in case of sick leave or vacation. It is a constant job of assessing the census, calculating the number of Mental Health Technicians and Mental Health Workers, and Nurses to meet state requirements and then to find those who have been pre-screened and who are available, and arrange for them to be on site at the right times. It is a daily job of flexing hours and finding available staff as mandated by the state regulations. It is likely that this problem results in lost revenue when patients cannot be kept because of unavailability of staff.

The PHF can supplement their census by admitting clients from other counties, which is cost efficient, but this is often difficult because of the unavailability of staff at the correct ratios. Thus, they routinely turn away patients from outside of El Dorado County, even when they are full; they reserve at least two beds for emergencies from within the county.

In spite of the limitations mentioned above, the staff size is conducive to networking with family, community resources such as vocational services, housing, Prospect Place, Oasis, medical, conservators office, etc. and in maintaining close contact with their patients. Most workers have been at the PHF for many years and are well versed on services and referral sources. They are a very dedicated group and seem well placed and satisfied with their work environment. Ms Hensley is superb at ensuring the good will of the staff and their cooperation in serving patients. A person is not discharged without a plan or a place to go.

RECOMMENDATIONS:

1. The PHF is quite small for the needs of El Dorado County; the space is well kept but cramped; and adequate office space is lacking. There is a hall that has doors going to senior center, which has substantially more space, but use of this space is not allowed. There is only a very small balcony for patients to go outside and no independent recreation or training/schooling area. Patients who exercise do so in the hallway, which is inadequate if more than one person is exercising at once. The hall is well lighted and doesn't seem to serve a clear purpose. It would be easy enough to modify the hall in order to add store/office space.

2. A review of computerized records would be helpful with special attention given to ways of easily identifying patient demographics for periodic review of those receiving services.

3. Patient computer facilities for e-mail and education are lacking or sparse and would be valuable additions. Additional exercise equipment would also be useful, if there were an adequate place for its use.

4. Patients in the Seclusion Room need to be released ASAP into a regular room. Staff needs to be especially attentive to the patients as this is an extremely stressful period of time for the patient. This room has an issue with temperature and needs to be monitored to make sure it is comfortable for the patient.

5. There is a hole under the patio area (probably an old mine shaft) probably cannot be filed in, but should at least be covered for safety.

6. It is important to prepare for the pending retirements of several workers within a relatively proximal time frame. Plans will need to be developed and resources provided to ensure continuity of care when multiple retirements or departures occur. Moreover, it would be valuable to add to the full time staff in order to increase the census and retaining the ability to take in clients from other counties. A higher census and larger space would probably pay for itself through the added income out of county patient care. Please note: The PHF is licensed for 16 beds and if it were to expand the facility to accommodate more beds, the PHF will lose Medi-Cal certification. 16 beds is the maximum number of beds any PHF is permitted.

7. It would be helpful to provide a Recreational Director to allow more physical activities with and for the patients. A larger facility and one with better use of outside-the-building activities may improve patient care.

8. The Patient's Rights Advocate is an advocate for the patient as well as the county. Priority should be high to offer her a private office and adequate time with patients and family. PRA services could prove valuable in assisting the county with grievances and taking care of issues thus preventing patients complaining to

the CDMH or Grand Jury.

9. Quality control and feedback may be facilitated by carrying out a periodic survey of former patients, to be conducted by an anonymous independent entity i.e. CASA, or the PRA.

10. Department should employ a Registered Nurse to facilitate with medication and physical illness.

11. Staffing is a major problem throughout the El Dorado County Mental Health System. Salaries are far lower than in comparable counties and this limits the ability to recruit and maintain staff. This general concern has direct implications for the Psychiatric Health Facility. For example, there is not a registered nurse on site at the present time. It is strongly recommended that steps be taken to secure a full time nurse, without whom it cannot be assured that patients will receive their necessary medications.

12. Salaries for professional staff throughout the system should be raised to be comparable to those in other counties in Northern California, in order to recruit and enhance retention.

PHF Fiscal
The PHF operates as a separate cost center within Mental Health which allows the department to track both revenues and expenditures. Ten years ago the PHF's operation was geared towards patient care first and fiscal prudence second. This approach worked during the early 2000's as total department revenues exceeded expenditures and the department was able to offset any funding shortfalls at the PHF and still grow a department funding surplus. As state revenue growth stagnated beginning in 2001-02 (i.e. realignment revenue), the department looked at other revenue options for the PHF, which included increasing the number of non El Dorado County patients.

In an attempt to increase the PHF' daily census the department increased the number of patient care contracts it had with other counties and added a contract with the Veterans Administration. With the additional patients the PHF faced the new challenge of balancing the patient census with state regulations, which requires higher staffing levels (and higher operating costs) for a census in excess of 10 patients. When additional revenues did not cover the higher expenditures, the department offset the shortfall with realignment revenues. The use of these realignment funds compete with and are being used to offset traditional Mental Health services provided by the department, services that are in a constant struggle with reduced state funding.

It should be noted that PHF revenues can exceed expenditures if the census approaches 15, but staffing availability and balancing the needs of El Dorado County patients make the decision to accept or decline new patients complex. PHF management has operated as well as can be expected without the benefit of a long term strategic utilization plan, but that time has passed and a long term utilization plan needs to be developed to assist PHF management. The Department has initiated a preliminary staffing analysis, but the analysis is just one component of a comprehensive cost/benefit analysis and corresponding operations manual/guide that should be completed prior to and in use by FY 2008-09.

The PHF's expenditures consist of salary and benefit costs, contractual staffing; services and supplies (i.e. food, office and medical supplies, equipment, janitorial services, medical laboratory, and transportation costs); utilities and county support costs. As is with most government organizations, personnel costs are the greatest expense. Annual cost of living salary adjustments and double digit health insurances increases virtually guarantee that salary and benefit costs will grow each year. At the same time the department faces the constant challenge of attracting qualified staff due to salary and benefit packages that are less than those offered by surrounding agencies. With these hiring challenges staffing the PHF has at times been a juggling act. When staffing shortages occur due to illness, vacation or the census exceeds 10 patients and state mandates require increased staffing levels, the PHF's procedure for staffing the monthly shifts is as follows:

1. Permanent full and part-time county staff
2. Non-overtime extra-help staff
3. Permanent staff that is overtime

4. Extra-help staff receiving overtime (also employed elsewhere in the county), and
5. Contract workers.

Overtime and contractual workers are the most costly of the staffing options and the revenues generated by the additional 1 – 2 patients generally do not cover the extra costs. Contract staffing is provided by an outside agency, is the most expensive option, and is the last option employed. Until recently the PHF had a shortage of extra-help staff from which to draw, however they have recently hired several people who will help reduce the need for contractual staff.

As for non salary and benefit expenditures, the staff at the PHF has done an admirable job of containing costs. In regards to facility requirements, the building is 45 plus years old and requires ongoing maintenance. During the last two fiscal years several capital improvements and upgrades have been completed at the PHF:

- Painted patient areas of the PHF.
- Installed two new seclusion room doors that allow staff to provide patients with their food and medications without opening the door (just under $20,000), thus reducing staff injuries from agitated and assaultive patients.
- Updated two patient shower stalls with faucets and handles flush with the wall, thus reducing the risk of patient suicides.
- Inserted a second door between the observation and common area as a safety measure for staff and patients.
- Replaced carpeting in four patient bedrooms.
- Purchased sanitizing washing machine and dryer to assist patients with washing their clothing while at the PHF.
- Replaced the kitchen stove.
- Installed outdoor safety lighting for crisis workers meeting with clients in the middle of the night, and for nursing staff coming to or leaving their shift in the dark.
- Installed Lexan material in interior windows, keeping staff, patients and their family safe.

FY 2007-08 Projects

- Purchase two new restraint beds.
- Paint the PHF kitchen
- Replace the carpeting in two offices.
- Improve the safety of the nurse's station by permitting another exit route through an emergency escape door/window.

Potential Future Projects

- Update the patient shower stalls and bathrooms with durable, easy-to-clean and repair materials.
- Upgrade security system.

- Cover hole under the patio area (probably an old mine shaft) for safety.
- Paint the administrative wing and deck area.
- Acquire additional space for a meeting room. Currently, there is no space for in-service training, staff meetings, additional storage, etc.

The following is a summary of the PHF's expenditures for FY 2004-05 through FY 2007-08.

El Dorado County Mental Health Psychiatric Health Facility
Expenditures: FY 04-05 thru FY 07-08

	FY 2004-05		FY 2005-06		FY 2006-07		FY 2007-08	
Description	Actual	Percent	Actual	Percent	Actual	Percent	Budget	Percent
Salary/Benefits Expenditures	$1,448,366	86%	$1,483,717	84%	$1,652,648	79%	$1,591,466	81%
Contractual Staff	-	0%	8,191	0%	116,859	6%	108,550	6%
Services and Supplies	66,858	4%	74,402	4%	103,972	5%	71,308	4%
Utilities	30,902	2%	33,115	2%	38,246	2%	36,000	2%
County Support Costs	38,505	2%	72,941	4%	86,932	4%	79,176	4%
Other Expenditures	104,274	6%	85,646	5%	100,992	5%	77,208	4%
Total Expenditures	**1,688,905**	**100 %**	**1,758,012**	**100 %**	**2,099,649**	**100 %**	**1,963,708**	**100 %**

PHF revenues consist primarily of MediCal; Veterans Administration payments; payments from other California counties; other payers (private pay or insurance); and realignment revenues. As this cost center must be balanced at year-end, realignment revenues are used to make up for difference between revenues and expenditures. Realignment revenues are available to Mental Health to backfill the funding of a number of their programs, therefore it is critical to optimize the use of realignment and enhance other revenue sources. Accordingly the PHF must strive to the program dependence on realignment revenues.

The following is a chart identifying PHF revenues for FY 2004-05 thru FY 2007-08.

El Dorado County Mental Health Psychiatric Health Facility
Revenues: FY 04-05 thru FY 07-08

	FY 2004-05		FY 2005-06		FY 2006-07		FY 2007-08	
Description	Actual	Percent	Actual	Percent	Actual	Percent	Budget	Percent
MediCal Revenue	$693,480	41%	$264,032	15%	$669,235	32%	$749,312	38%
VA Revenue	68,050	4%	161,700	9%	89,300	4%	50,000	3%
Other CA Counties Revenue	213,189	13%	356,009	20%	346,239	16%	302,000	15%
Other Payers	46,677	3%	47,733	3%	175,527	8%	50,000	3%
Miscellaneous Revenue	4,306	0%	4,628	0%	3,854	0%	5,000	0%
Realignment Funds	663,203	39%	923,910	53%	815,494	39%	807,396	41%
Total Revenue	**1,688,905**	**100 %**	**1,758,012**	**100 %**	**2,099,649**	**100 %**	**1,963,708**	**100 %**

Excluding FY 2005-06, approximately 30% to 40% of the PHF's revenues are derived from MediCal reimbursements (the PHF receives approximately $293 per patient per day). Approximately 15% of the revenue comes from admitting patients from other counties; and a combined 10% from Veterans Administration clients and private and other insurance payments. As previously mentioned realignment funds are used to offset the gap between revenues and expenditures. Although the percentage of realignment versus total revenues has been fairly constant over the years (40%), the dollar amount has increased from $663,000 in FY 2004-05 to $815,000 in FY 2006-07. As State realignment revenue does not grow fast enough to cover these increases, it is critical that the department exercise extreme effort to make the PHF cost effective and reduce its reliance on realignment revenues.

The department has identified several revenue generating options. The first option is to increase the daily rate for first day the patient is at the PHF. Day one is the critical day and requires the most activity on the part of the physician, nurse's staff and social worker, including a complete psychiatric assessment. Increasing the day one rate will help offset this additional work.

The second option is to contract with private insurance companies to increase the day costs and the census. These contracts have the potential to provide a daily rate that exceeds that of our out-of-county contracts and can be utilized to maintain maximum census.

The third option is to renegotiate the county contracts for a higher daily rate. The impact of this option is somewhat limited as a number of the existing contracts do not expire for

1 – 2 years. The department would have to either terminate and renegotiate the contracts; or wait until the contracts expires and then renegotiate. If the department chooses to terminate the existing contracts, they could suffer a loss of goodwill with the counties or lose their business entirely as there are two new private PHF's in Marysville that are viable alternatives. The department also suggested that they require the other counties to bill for their own MediCal and/or other insurance reimbursement, as opposed to having the PHF complete this task on their behalf. It is not anticipated that this option will generate additional revenue but it could decrease EDC staff time spent on billing and reduce the time required to realize the revenues.

It does not appear that any one single funding option will provide the additional revenue to fund the PHF's operations. The department recently performed a patient and staffing analysis that determined that if the patient census exceeds 10, the PHF must have at least 13 patients to break even or generate revenues in excess of expenditures. The study also determined that if the PHF's census remains at 11 – 12 patients for an extended period of time, the department runs the risk of expenditures exceeding revenues and thus requiring more realignment revenue. As mentioned previously, this staffing study is just one component of a detailed cost/benefit analysis that needs to be performed to determine the future utilization of the PHF. The analysis should include but not be limited to the following three utilization options, or hybrids thereof:

- Maintain census of 10 beds or less. With this option staffing levels are constant, revenues are more predictable and most of the operational uncertainty is removed.
- Maximize use of the facility and its revenue potential. If the department chooses this option it must have a funding and operational plan/model in place. The plan must address staffing requirements, including minimizing staffing costs for an 11 – 12 bed census; a plan to maintain a census of 13 – 15 patients; and additional out-of-county and private insurance revenue.
- Close the PHF and contract with private hospitals for bed space (i.e. the private PHF's in Marysville). This could reduce the use of realignment revenues in providing PHF related services, however there are many concerns, including but not limited to patient care, access to patients for family members and department staff and the additional expense due to distance and travel, and impacts on local law enforcement agencies (operational and expense) and the courts.

It is important that the cost/benefit analysis identify and quantify the non-fiscal impacts to the department, the patients, family members, department staff and the community. The study should not lose sight of why the county has maintained a PHF and the successes that it has had. When complete, the department should present the analysis and recommendation to the Mental Health Commission and other decision makers for review and input. Once a course of action is chosen, the department then needs to prepare a strategic work plan, an "operations manual/guide" based on that plan, and a methodology to monitor progress in meeting the clinical, operational and funding goals. As part of this process the Mental Health Department would perform an annual assessment of the PHF and make the assessment available for review by the Mental Health Commission.

Recommendations:

- The Mental Health Department prepares a detailed cost/benefit analysis to determine the future utilization of the PHF. The analysis and recommendations should be presented to the Mental Health Commission and other decision makers for review and comment. This analysis should be completed by April 2008.
- Once option is chosen, the department prepares a strategic work plan, an "operations manual/guide", and a methodology to monitor progress in meeting the clinical, operational and funding goals. The work plan, "operations manual/guide", and a methodology to monitor progress in meeting the clinical, operational and funding goals need to be in place prior to July 1, 2008.
- The Mental Health Department performs an annual assessment of the PHF and makes the assessment available for review by the Mental Health Commission.

El Dorado County Mental Health Commission
Onsite Evaluation

Program Contacted: Barton Memorial Hospital ER
Address: 2170 South Ave. South Lake Tahoe, CA 96150
Date of Contact: October 16, 2007

MHC Contact Team: Bob Bartley, Denise Burke Co-Chair, Diana Hankins, and Family member Ruth Barley

Persons interviewed: Lisa Fisher, Social Services Nurse Manager Emergency Case Management Manage and Toni Willen, RN, BS, CEN

The only hospital in South Lake Tahoe is Barton Hospital, where a lot of the mentally ill end up when in crisis for medical issues or mental health issues. All physicians and nurses in the ER are certified, and all the nurses are full-time Emergency Care Nurses. All had some psychological training before graduation. The last training done here by the Tahoe Mental Health Clinic was about six months ago. Most clients are brought in by Police Department as first responders, fewer by the Sheriff's Department, and few by family members. Most of course, have dual diagnoses. There seems to be a seasonal effect. There are times when there are no clients, or one or two clients, and then a cluster all at once.

There is a Memorandum of Understanding (MOU) between El Dorado County Mental Health and Barton that Mental Health will come in a timely manner, which should be within one hour, to evaluate someone who is in crisis. Mental Health can meet this mostly during the day on week days, but beginning at 5:00 p.m. it takes much longer, which puts stress on the hospital because they need the room for other emergency patients. Peak times after 5:00 p.m. can result in delays, due to lack of emergency room space. When a person in crisis is brought in, they are placed in a room. It is not always possible to have someone sit with them while they are there so they may be placed in a room where they are very visible, so they can be watched and checked frequently. How long law enforcement personnel remain depends on the severity of the crisis, meaning the degree of danger to self or others. A new law takes effect in 2008 which requires having someone sit with them in the room. They do this now when possible and if there is someone who can do so. After 5:00 p.m. and on weekends there are problems that arise because Mental Health has an answering service for Lake Tahoe crisis line. The Placerville Psychiatric Hospital takes crisis calls instead of the MH here in Tahoe at night and on the weekends.

Getting through to a Psychiatric Emergency Service worker often takes too long, and the hospital nurse at Barton cannot be kept waiting while the answering service either tries to contact the person who works crisis or is put on hold because they are busy. Nurses say they can be kept on the line as long as 10 to 15 minutes. Barton Hospital staff has finally asked the answering service to call the ER back once they find someone because they

need to handle other people who are being brought in for emergency needs and do not have people who can just sit on the phone and wait.

When a 5150 is written up by the police, Mental Health can override and not send the patient to the Placerville Psychiatric Hospital. If a physician in the emergency ward disagrees, Mental Health can override their decision as well. There have been times that a Barton Hospital physician strongly disagrees with the Mental Health crisis worker about a person not being sent to the PHF. If another crisis worker from MH is asked to reevaluate, the second worker seems to agree with the first evaluation most of the time. Perhaps the hospital knows more about the history of individual they are dealing with and their input should be considered important, especially if it is a patient who continues to be having a problem over and over again and it is recorded in their file at Barton. Some who are there for crisis are not already Tahoe Mental Health clients, and therefore not known by the MH crisis worker. They have tried to have physician-to-physician calls.
That has not worked well either. It was said that even if the MH crisis worker is trying to get someone into the PHF unit, they are often refused as well. Is this because of space or the contracts to other counties or not enough staff? There are real problems if a youth is brought in because there is usually no place to send them. Barton cannot transfer over the State Line.

When a client is mentally ill and intoxicated and MH will not evaluate them, Barton staff leaves them in the ER, and calls MH after the alcohol level drops below a certain level. This is a problem when dual diagnosis is an issue because there is no safe place to hold them for an evaluation. Barton Hospital talked with Dr. Sandra Branton and with Berry Wasserman to discuss these issues, but they still have not been resolved. Working together can be more effective to assure that those with Mental Health issues get the help that is needed for them. A crisis is a time-sensitive problem. Dr. Sonja Rupp, a child psychiatrist who works for our MH Clinic here in Tahoe part time is now under contract with Barton, but she works mostly on cases where the patient is an admitted patient at Barton. This new contract has just started. They are hoping this is going to help with the clients getting the help they may need, even if it is at the Placerville Hospital, and that there will be more collaboration here between physicians when there is a need. Dr. Rupp is available only Monday through Friday 9am to 5pm at Barton.

When a person leaves the emergency room and is not seen by Mental Health because private insurance coverage is not available for the MH Department, they are referred to a psychologist who in turn can recommend meds to a regular physician and get them medication in that manner. That sounds a bit dangerous if the regular physician or psychologist doesn’t understand psychiatric meds, which can be quite dangerous for the mentally ill. If they are on other medications for other physical ailments, this could create problems. There are only two psychiatrists in our area. One is Dr. Rupp, who sees only children at our Mental Health Clinic part time, and the other is Dr. V. Bry, who works with the Tahoe Mental Health Clinic part time. Barton Hospital will also try to set up an appointment with our MH Clinic, but MH will tell Barton that the client must present himself in person at the MH clinic to get an appointment. This can delay treatment, as it can be several weeks before a person can even see someone. Why can’t the triage team or

the crisis worker see them as soon as possible to determine if the person can get in to see the only MH physician here in Tahoe or the only licensed psychologist in the Mental Health Clinic? If meds are needed, it can be done more quickly and they can be helped or observed. The individual may cancel the appointment but at least they know there is help available and they have been referred. **It is not possible** for the Barton Hospital to put in a 23-hour holding facility. **It is not possible** for them to hire a Psychiatric Nurse Practitioner because of good use of their time and the cost involved. **It is not possible** to have MH work out of their facility because there would be times they are not needed.

There are several things that Barton Hospital feels could help MH Clients receive better care.
1. Better relationship with the PHF Unit.
2. Physician-to-Physician phone calls so they can get help when they need it.
3. Better trained crisis workers who are looking out for the client.
4. The ability to make appointments for the clients they are concerned about at Mental Health.
5. Extended license for the PHF unit to be able to deal with clients with wheel chairs, IVs, and other physical issues that clients have when it is their mental health issue that is the major problem.

Good question from Barton: How do people know whom to call in a crisis if they have not been part of Mental Health before? (In fact, there is a listing for “24 Hour Crisis Line” in the Government pages in the Phone Book, under the El Dorado County heading.)

We feel that there doesn’t seem to be a good relationship between Mental Health and Barton Hospital. It is a real issue because we do not have a facility in town, like the hospital in Placerville, to help out when there is a crisis for an individual. There is no place to put a person who may be a danger even if they sign an agreement not to hurt themselves, which protects MH but not the individual. We have had clients, after signing that agreement, proceed to hurt themselves or hurt others. Because of this we feel that the Placerville Psychiatric rules for working physician-to-physician, and getting appointments made for those in need should be considered for adoption in Tahoe. A compromise is needed that will work for the mentally ill, Barton, and Mental Health, in a locality where there is not a Mental Health Hospital, or 23-hour holding area, or a crisis intervention unit, or a transitional care home.

Suggestions:
A response to mentally ill crisis events must be immediate. Offering an immediate humane and calm approach of care gives consumers a sense of dignity. This dignity generates a new respect for crisis workers, the hospital, and anyone else involved. Wouldn’t it be nice if a person who recognizes they may be going into a crisis had a place they could walk into and get help before it became full-blown in the evening or weekend as well as they can during the day? Nights are the worse time for most of the clients.

Different strategies have been developed elsewhere to provide help. A mobile team of police, a Mental Health professional, or both, to respond to a person breaking down or

who has a mental illness. Another widely accepted strategy uses psychiatric emergency teams of MH professionals who are part of a local community MH service system which has developed a special arrangement with the police department to respond to special needs **at the site** of an incident. Another model deploys teams composed of both specially trained sworn police officers and a Mental Health professional employed by local community Mental Health Department. These teams have been shown to be effective in resolving emergency situations in the community involving persons with mental illness and in diverting them to the Mental Health system rather than to the criminal justice system. It also saves the county money spent in transportation and hospitalizations. Nevada County has a seven-bed house they use for crisis and holding, and the crisis line is at the house. A crisis worker is there all the time. They use this as a hold if possible instead of taking them to jail. They also have a house for longer term transition which is voluntary and unlocked with round the clock staff which is not highly trained but it works. Nevada County is implementing Laura's Law as well. Perhaps someone from our county should visit this County and see how they work this crisis intervention. They are a small county, and just like we here in S.L. Tahoe, have no psychiatric hospital nearby. Ben Lopez in Auburn, with a company called Crisis Team Support Counseling Services, is contracted for support in crisis intervention. San Mateo County has a program called SMART, (San Mateo County Mental Health Assessment and Referral Team), a joint venture with the Health Department, Mental Health, and the Paramedic Department, contracting with American Medical Response West (AMR). AMR operates nationwide, and has contracts with several California counties. There is a psychiatrist available for consultation as needed. A clinician based in MH Division coordinates referrals as needed (during working hours) and a phone line for immediate needs for dependent adults during nonworking hours. It is a way they manage pre-hospital calls for behavioral emergencies. They have a county-trained paramedic who assesses Mental Health patients, practices techniques for managing people in crisis, and has referral options for county programs. SMART paramedics are linked to County Mental Health professionals. They assist in deescalating a situation, determine best option for meeting the client's needs, decide between immediate/urgent and non-urgent intervention, and do any needed 5150 placement and transport. Santa Barbara County has a similar program. These programs keep clients from entering the 5150 pathway when it isn't needed and provide the client with services to best meet their need. They offer options for clients not requiring 5150, and stop people from falling through the cracks. They provide the ability to track people through the system and find out if they are getting their needs met and help in getting to know the "frequent flyers" and there is a team approach for these challenging patients. A nonprofit company called WestCare has offices in California, Nevada, and Arizona they are setting up a new service in Reno in February of this year that will be like a 23- hour triage. They are doing more and more for the mentally ill and they may be willing to work with us here in Tahoe. Their phone number in Fresno is 559-453-6969.

Our county should look at these programs and modify them to fit our needs in El Dorado County, as we did with the Behavioral Health Court. An answering service and waiting on the line are not the way to handle crisis intervention. There are other communities that have a crisis van that goes out on calls, or they contract out for emergency care after

hours. There are counties that have crisis workers working together with law enforcement. Even one life is worth saving. Perhaps we need to look to Prop 63 to find a way to be able to find a service whereby Tahoe can get the help that is needed for crisis for our youth and others who need crisis intervention and a way to give them help **at that moment in time.** We are part of El Dorado County, even though we live in Tahoe. It is time that we have more than an answering service for crisis intervention in our community. Yearly the Mental Health Commission has been requesting this.

RECOMMENDATIONS MENTAL COMMISSION – 2008
BARTON HOSPITAL – SOUTH LAKE TAHOE

- Barton Hospital is where mental health clients in South Lake Tahoe are transported to when they are in crisis, as this the only hospital in the area. They are not equipped to handle a person in crisis for more than a few hours, and therefore, need a better system from Mental Health to help deal with crisis situations.

- We need better communication between Barton Hospital and Mental Health. We need a liaison person who understands both Barton's and Mental Health policies.

- The client who is in crisis in the emergency room should be seen by someone from Mental Health within 1 hour.

- Barton would like to help people who in crisis make an appointment by phone with Mental Health so that they may get further help. Hopefully, this would cut down on the number of times Barton would see this person in the emergency room. The client should be seen at Mental Health within a reasonable amount of time by a Mental Health clinicians or psychiatrist. They should be seen within 72 hours.

- Barton's doctors should be able to talk with the doctors at the Psychiatric Health Facility and Mental Health directly. Their opinion should be considered regarding the client they have in their emergency room, as to whether they should be 5150.

- Check out other options for dealing with a client being 5150ed. Some very good options are attached in the full report.

- Setting up the crisis line to work better so that Mental Health is interacting with the clients more, and therefore they may spend less time at Barton Hospital.

- Barton would like see better trained crisis workers responding in the emergency room.

2008 Mental Health Commission report on SLT Crisis Line – "Cover Sheet"

The official name of the Crisis Line program is Psychiatric Emergency Services (PES). The budget for the PES for Fiscal Year 07/08 is $107,136.

The PES phone number is in the Government section of the White pages in the phone book, and could also be found by appropriate Internet search.

The PES operates 24/7. Calls to the number in the phone book go first to an answering service, and are redirected to either Placerville or SLT.

During business hours, PES staff work at the clinic, one crisis worker per shift. After-hours coverage is provided by staff that is on-call. Both licensed and unlicensed staff provide coverage, in roughly equal numbers. Staff is offered comp time off or overtime pay as incentive to volunteer to serve outside of regular office hours.

PES staff responding to the calls make an assessment of the client's situation, and can request emergency transportation to Barton or the Placerville 24-hour facility if needed. Calls are logged, and if the caller is already a SLT MH client the call is entered into client's chart. The responding PES worker may pass the case on to the PES worker on the next shift for follow-up. Follow-up may be face to face or over the phone depending on need. A welfare check may be made with law enforcement if needed.

Using the month of May 2007 as an example, out of the 30 crisis contacts during the month (this includes phone as well as face to face contacts), 14 were SLT MH clients and 16 were not current clients.

There is no budget for hiring full-time crisis workers to staff the service separate from the existing full-time staff. Were there allocated funding, SLT MH would have a 23-hour facility in SLT, or would contract to admit clients to a WIC 5170 facility, for 72-hour treatment and evaluation of inebriates. A 5170 client is dangerous to self or others as a result of inebriation.

Current plans include searching for and hiring a full-time, supervising psychiatrist who will bring clinical and administrative expertise to the SLT and Placerville psychiatry emergency services.

Anecdotally, some clients have reported being placed on hold for long times, and there are some other concerns about the answering service aspects of the PES. SLT has no Mobile PES team that can "roll" to a client location when needed. There are anecdotal reports of law enforcement officers telling clients that they are not a "taxi service" when called upon to provide transport to Barton. Transportation is a significantly weak link in the PES chain.

Psychiatric Emergency Service, also known as Crisis Line

R. S. Lynn, PhD, with no previous knowledge of the SLT MH program, prepared the following questions. The questions (generally not in italic type) were delivered to the SLT MH office on or about 08/31/2007. Dr. Branton supplied responses (generally in italic type) on 11/02/2007:

1. What is the official name of the Crisis Line program? *Psychiatric Emergency Services (PES)*
2. Please furnish the mission statement for the program. *The Mission Statement for the Mental Health Department is:* ***The El Dorado County Mental Health Department strives to alleviate the pathos of mental illness by providing recovery-oriented, client-centered, culturally competent treatment services in collaboration with clients, families and community partners. The Department seeks to eliminate disparities in service access and to reduce the stigma associated with mental illness while offering the highest quality behavioral healthcare to improve the community's health and safety, to strengthen individuals' resilience*** and ***to promote restoration of healthy families.*** *The mission of psychiatric emergency services is to follow the Department's mission the provision of services to consumers experiencing psychiatric emergencies or urgent conditions with emergency evaluation and consultation, inpatient psychiatric hospitalization, or crisis intervention services as appropriate.*
3. Is this program a specific line item in the budget of the SLT Mental Health operation? *No, the SLT program is not a specific line item within the SLT MH budget, but rather has its own separate budget as a separate program in SLT. The budget for SLT MH is the aggregate of several SLT program budgets (e.g., Children's, Day Rehab, and the former TOP budget). Examples of a budget line item would be food, utilities, etc.*
4. What is the amount allocated to the SLT Crisis Line program current Fiscal Year (FY)? *The budget for the current FY, 07/08 is $107,136.* Last FY? *The budget for 06/07 was $100,710* Next FY? *The budget for FY 08/09 has not been established, but will most likely be in the neighborhood of $115,000.*
5. What are the hours of operation for each day of the week? *24 hours a day 7 days a week.*
6. What is the depth of coverage for each day and time of day? *One crisis worker per shift. Shifts are 8AM to 5PM, and 5PM to 8AM Monday to Friday. Weekends and holidays are 8AM to 8PM, and 8PM to 8AM. After hours coverage is provided by staff who are on-call. During business hours, staff work out of the clinic.*
7. Describe holiday coverage. *See #5*
8**.** By personnel classification and licensure, describe the staff who provide the coverage. Furnish copies of the current or most recent job announcements for these classifications. *The job descriptions for Mental Health Workers, Psychiatric Technicians and Mental Health Clinicians are attached.* ***For additional job class information, see http://www.co.eldorado.ca.us/sigma/InfoListings.aspx***
9. In a typical month, or for such time span as these statistics are gathered, provide the number of Crisis Line coverage hours by each personnel classification. *This varies.*

However in September, out of 60 shifts, 26 were covered by Mental Health Clinicians, 4 by the Psychiatric Technician, and 30 by Mental Health Workers.
10. Do the staff personnel have other duties or responsibilities during the time they provide Crisis Line coverage? *During the daytime, yes, they may provide assessments for new clients or do their paperwork.*
11. Are some of the covering staff subject to Wage/Hours labor law provisions, while others are exempt? In what proportions? *All permanent staff are subject to applicable county and MOU Local 1 provisions, as well as applicable labor laws. On-call coverage is specifically covered in the MOU. All staff that are currently working PES are permanent employees.*
12. Describe overtime pay as it may apply to the program. *See Attachment from the Local 1 MOU.*
13. Describe how staff are rotated for Crisis Line service. *Volunteer during our PES meeting.*
14. How many telephone lines are used in the program? *One line with a rollover, that allows two callers on separate phone lines to call our crisis line, and live operators from the answering service respond to both callers simultaneously. We just tested the line again on 10/24/2007, and the answering service responded appropriately to both callers.*
15. How is the telephone numbers publicized? *Telephone book, internet.*
16. What are the provisions for routing calls if phone lines are busy? *The rollover line enables the answering service to respond to up to two callers at the same time from So. Lake Tahoe. However, if two callers on separate phone lines have already called in, a third caller would receive a busy signal.*
17. What are the provisions for routing calls during times when there is no coverage? *There is always someone who has signed up for each shift, in the event the PES worker does not respond, the answering service will call the other staff participating in PES coverage, Program Coordinator, and Program Manager.*
18. Describe the triage protocol employed by staff. *1) Meeting 5150 criteria for Danger to Self or Others, or Grave Disability due to a mental disorder and medically cleared 2) Meeting medical necessity for voluntary psychiatric hospitalization 3) Evaluation and crisis intervention or referral (drug and alcohol treatment, medical, outpatient mental health, crisis follow-up).*
19. Describe the range of responses staff can take, based upon their assessment of the situation. Include consideration of time of day and day of week. *Evaluate and hospitalize under 5150 or voluntarily, to a private hospital if there is a bed available and the client has insurance or Medicare, or to the PHF if MediCal or no benefits. Evaluate and provide crisis intervention, referrals, and follow-up, including follow up for outpatient mental health services. Consult with psychiatric medical back up as needed, consult with ER physician for medications as appropriate.*
20. What is the system for insuring appropriate follow-up when it is considered called for? *Pass on to the PES worker on the next shift for follow-up. Follow-up may be face to face or over the phone depending on need. A welfare check may be made with law enforcement if needed.*
21. How are calls logged? *Clinical documentation on crisis note, PES log, billing sheet.*

22. Is there an attempt to make any kind of preliminary DSM Dx of the callers? *A DSM IV-TR diagnostic impression is only made if the client is seen face to face, or if the client is already a client of EDCMH, a diagnosis has already been made.*
23. What kind of assessment of global adjustment or degree of severity is made at the time of the call? *For phone calls, an emergency assessment is made about the severity of the issue, danger to self, danger to others, or grave disability, and a determination is made if the client needs to go to the ER for further face to face evaluation. If the information is provided by the client, the information may be given to law enforcement to check on the client=s safety or bring the client to ER for further evaluation. For face to face evaluation, a GAF (Global Assessment of Functioning) is provided with each assessment, and clinical assessment of the degree of severity of mental illness, suicidality, or danger to others provided.*
24. Is there a periodic written summary of activity for management review? Weekly, Monthly? *I review PES logs periodically. The logs are turned in at the end of each shift and placed in a binder so that the staff or myself could easily look up a contact or review data.*
25. Describe this written summary and its distribution. *The PES logs are kept in the front medical records area, locked up at night for confidentiality. They are available to any manger or clinical staff member who needs to review them. Review-we have 25% of the volume of crisis contacts when compared with Placerville.*
26. During the period covered by the summary, what percentages of callers are first time, second time, third time, etc.? *I have not analyzed the percentage of callers as first time, second time, and third time.*
27. What proportion of callers is known to be already SLT MH Dept clientele? *Using the month of May as an example, out of the 30 crisis contacts we had during the month (this includes phone as well as face to face contacts), 14 were clients and 16 were not current clients.*
28. If a caller is known to be already among the SLT MH clientele, is the called added to the client=s chart? *Yes.*
29. What is the impact of budgetary restraints on the program? *Budgetary restraints preempt hiring full-time crisis workers to staff the service separate from the existing full-time staff. If unlimited funding were available, we would have a 23 hour facility in SLT to admit clients to or we=d contract with a 5170 facility. However, the only 5170 facility I am aware of is in Sacramento. A 5170 facility is a facility designated by the county and approved by the State Department of Alcohol and Drug Abuse as a facility for 72-hour treatment and evaluation of inebriates. The 5170 criteria parallels 5150, except that the client is dangerous to him or herself or others as a result of inebriation*
30. If there were no such restraints, what would be the ideal staffing and coverage times? *As above in #29; A psychiatrist with good engagement skills and knowledge of both mental health and substance abuse treatment on duty 24/7, with the back up of a second similar psychiatrist to be available when the first is busy with a crisis contact.*
31. What other program changes would lead to a better program? *Recruitment and hiring of a full-time, crisis-trained psychiatrist.*
32. What are current plans for making changes to the program? *Current plans include searching for and hiring a full-time, supervising psychiatrist who will bring clinical and administrative expertise to the SLT and Placerville psychiatry emergency services.*

33. Please furnish such additional information as SLT MH leadership consider appropriate for the Mental Health Commission to include in their report to the BOS. (There were no responses.)

Follow-up to above responses

I submitted these follow-up questions on December 13, 2007, and received responses on January 14, 2008.

9.2 For the current staffing at SLT, including those who do not serve in the PES function, without reference to individual names, please describe the highest degrees and licensure of MH Clinicians assigned to SLT. (Note: MSW = Master of Social Work, LCSW = Licensed Clinical Social Worker, which has significant requirements in addition to the Master's Degree, RN = Registered Nurse, MFT = Marriage & Family Therapist, MFTI = MFT Intern, EdD = Doctor of Education.)

Those PES staff on the January 08 schedule: 4 MSW's, hired as Mental Health Clinicians 1 MSW, who is also an LCSW, hired as a Mental Health Clinician 1 RN, who is hired as a Psychiatric Technician 1 MA, MFTI, hired as a Mental Health Clinician 1 MA, MFT, hired as a Mental Health Clinician 3 BA level staff, hired as Mental Health Workers. 2 are in graduate programs, 1 is an MFT trainee.

9.3 Of the total provider staff, presumably there are some who do not serve in the PES. Please describe them by job title and number. Similarly, please describe, in terms of highest degree and licensure, the staffing by the other two job titles; Psychiatric Technicians and MH Workers. Presumably some MH Workers have educational attainment greater than the minimum required.

Listed below are additional SLT clinical staff who are not scheduled to provide PES coverage: 1 MSW, LCSW Program Coordinator 2 Mental Health Workers, years of experience, almost have an AA Degrees. 1 is full time, 1 is part time 1 Mental Health Worker, 10 years of experience, has an AA Degree, part-time extra help. 1 MA, MFTI, Mental Health Clinician, part-time extra help 3 MH Aides, part time extra help, some college classes. 1 EdD Licensed Psychologist, Program Manager

16 & 17 During the regular daytime hours weekdays, are the Crisis Line calls received directly at the MH Offices?

The 544-2219 number is answered by the answering service. However, law enforcement, the jail, Barton, and most of our clients will call the clinic at 573-3251 during the day if there is an emergency.

Do overflow calls during these hours go to the answering service?

If the call comes through the crisis line 544-2219, the overflow calls go to the answering service. The overflow calls to the office number 573-3251 go to another clerical staff member.

During other hours, do the calls go directly to an answering service?

The crisis line, 544-2219, is always answered by our answering service.

Under what conditions are calls routed to Placerville?

Between the hours of 12:30AM and 6:00AM, the answering service will refer crisis calls to the Psychiatric Health Facility in Placerville.

Is there any estimate of the numbers of unanswered calls in a given time period? Due to busy followed by hang-up?

No, but according to the answering service, there should not be an unanswered call.
Is there an estimate of the number of calls put on hold during a given time period?
Again, according to our answering service, this should not occur. I did test the system today with 2 calls on 544-2219 at the same time, and both were answered promptly.

Comments by R. S. Lynn, PhD
On one of the calls I made to learn more about the PES, on a weekend, the answering service referred me to the telephone number of Placerville MH without asking me my location. Only when I commented that it was a long distance number did the service operator seem to wonder if I were in the SLT area. The answering service seems to be for both west slope and SLT calls, and the operator cannot tell the origin of the calls.

No member of the MHC has yet performed a systematic test of the answering service system, using test calls. Without full discussion, and acquiescence, among the members of the MHC serving SLT, I would not propose that simulated crisis calls be made by MHC members.

SLT MH consumers have reported being placed on hold and other difficulties in getting through to a PES provider. No comprehensive survey has been conducted among samples of MH consumers nor among PES providers, and this would seem appropriate as material for future MHC reports.

As a retired clinical psychologist from LA County Mental Health Dept, I know something about its mobile PES teams. The smaller rural counties have fewer resources, along with fewer problems of course. But they still must be able to respond adequately to mental health emergencies. SLT has no Mobile PES teams to provide 24/7 services to those clients and potential clients who phone the PES. The lack of a system to get trained MH clinicians to a client location as needed, and the lack of a smoothly operating system to get clients to Barton when it might be called for are deficits that need remediation. In some cases, it is not reasonable to tell a client to get himself to Barton for intervention. The transportation problem is a weak link in the PES system.

The El Dorado County Health Officer informs us that the County suicide rate exceeds national targets for suicide by a factor of three. This fact should motivate the improvement of the Crisis Line program.

I had wanted to know if those serving the PES were, on average, of lower classifications and qualifications than the overall staff average. The responses indicate that this is not the case. It did seem to me that the SLT staff has a lower average level of licensure and graduate degrees than clinics I am familiar with in LA County.

For the next report on the PES operation at SLT, I will want full and timely answers to the all questions posed in the original inquiry, and in its brief follow-up, and to all questions developed in the meantime. The two-month wait for responses to the original

inquiry, and the one-month wait to the follow-up questions were of some hindrance in preparing this report.

El Dorado County Jail in South Lake Tahoe

On August 1, 2007, Lt. Randy Peshon gave the SLT MHC some information about the jail. The El Dorado County jail is a type II facility. It has a similar structure as a big city jail but on a smaller scale. Tahoe has 150 beds & Placerville has 300. Hopefully the Placerville site will be able to double in size in the next 2 years. One day Lt. Peshon was approached by the SLT NAMI about the problem of offenders with mental health issues. After spending most of his career putting people in jail, he is now working on keeping people out.

El Dorado County is the 12th county in California to start a Behavioral Health Court. The six entities involved in South Lake Tahoe are: Mental Health, Judge Kingsbury, the Police Dept., the County Sheriff, the Public Defender and the District Attorney. The Behavioral Health courts are known nationwide thanks to NAMI.

Some of the highlights of Behavioral Health Court and other programs at the jail: Creative sentences are crafted to keep people out of jail. Mental Health programs are advocated for those in need of them such as TOP. Line staff are learning to recognize developmental disabilities. Teachers are coming in to the facility to help students get their GEDs. They also teach English as a second language and culinary arts at the college level. Six students have recently received their GEDs and the culinary program is so successful that they are able to do catering for a small fee that covers costs. The jail bakers swept the awards at the county fair! There is a 40-hour staff training to keep inmates out of jail. Crisis intervention has been stepped up to keep people out of jail. Probation meets with Mental Health once a month for referrals, although Probation is overloaded. The Court team meets every two weeks and outreach can be immediate, depending on Amy's caseload. Now that there is a 24-hour nurse available, more injuries and mental health issues are being caught. Medications can be brought in if they are in an original container and with approval of the nurse and doctor. The MIOCR (mentally ill offender crime reduction) grant finished #1 of all the grant proposals in the State. Lt. Peshon is working on a day reporting program where inmates can work and still serve their time. He is also working on a program to start 60 days before release. Inmates will be involved in a work program with referrals for housing, mental health services and help from the Sierra Recovery Center when needed.

Lt. Peshon explained further about the Behavioral Court process. It is based on pretrial proceedings. The clients plead guilty and then are put into the program as part of their probation. There is no one in the program that has pleaded not guilty.

Some other pieces of information that Lt. Peshon gave the commission was that approximately 30% of jail inmates are mentally ill. The Behavioral Court in Placerville is similar to the one in South Lake Tahoe but they both have their own styles. The South Lake Tahoe Court likes to think outside of the box. The maximum population at the SLT

jail is 158 and segregation is important to keep order. The inmates are put into pods and are changed periodically. There are eight maximum-security cells. 30 beds are for female inmates. Women are sentenced mostly for drugs and alcohol. They are getting in trouble more in domestic violence cases as the primary aggressor.

Lt. Peshon is very interested in connecting the jail back to the community. All of the new programs are helping with the inmate's quality of life and the programs also save the county money.