Mental Health System and Budget Crisis
In Contra Costa County, FY/16/17

Executive Summary

This White Paper is a collaborative effort of the Contra Costa County Mental Health Commission (MHC) and Behavioral Health Services (BHS) with the support of the Behavioral Health Care Partnership (BHCP) to encourage discussion around the current crisis in the county public mental health care system and deficits in the county mental health budget process that contribute to this crisis. The paper's objective is to 1) focus attention on key symptoms of the crisis, and 2) inspire collaborative, creative problem-solving and solutions that build on our many strengths while overcoming budgeting challenges for the greatest impact on the well-being of the seriously mentally ill. This paper is presented to the Board of Supervisors for consideration during the current fiscal year 2016/17 budget planning cycle as well as future cycles as we continue to strive to provide the best mental health care possible for those most in need in Contra Costa County.

Key points of this White Paper describe:

- The wake-up call of the crisis at Psychiatric Emergency Services (PES) that points to an impacted system that is unable to provide the right treatment at the right moment and is therefore struggling to truly meet the needs of the seriously mentally ill;

- The compromised ability of the Adult clinics and Child/Adolescent clinics to meet the needs of patients due to understaffing as evidenced by three to four month wait times and a migration of patients in crisis to PES for intervention that is not meant to be a stand-in for treatment;

- The adverse lack of support for families, who are so critical to diagnosis, support and treatment, due to the absence of Family Partner positions in the Children/Adolescent clinics and unfilled positions in the adult clinics;

- The deficit of treatment capacity for children and adolescents due to the lack of in-patient and residential beds (lack of contracts), an insufficient number of clinics, and understaffing, and the resulting increase in the number of children presenting at PES, cases of children staying at PES for multiple weeks and months, and cases of children placed in treatment far from home and their families;

- The underlying theme of inadequate staffing levels due to the inability of treatment facilities to attract and keep high quality psychiatrists and nurses because of un-competitive compensation and such practices as the closing of lists; and

- The underlying theme of dedicated, quality staff struggling to offer excellent care but undercut by budgets that are generated by a formulaic, top down process rather than a process that builds up a budget from program needs.

In considering these challenges, perhaps the most critical step in solving our county's mental health crisis is to allocate funding in a way that meets patient needs at every level along the continuum of care. With program needs driving the budgeting process, we will create fiscal and human savings through our ability to treat illness before it enters the crisis state.

Taking a Close Look

In accordance with our state mandated duties outlined in WIC 5604.2, the Contra Costa County Mental Health Commission has performed due diligence in reviewing the traditional budget process for the Mental Health system. Through our committee work, site visits and collaborative efforts we have studied fiscal documents, outcome based data and received testimony from consumers, families and providers. We have also read numerous reports, articles and studies on the complexity of financing the California mental health system. Based on this collective learning, the Contra Costa County Mental Health Commission requests that the Board of Supervisors rethink the traditional budget process for the public mental health system of Contra Costa County and recognize the existing system crisis.

The Crisis at Psychiatric Emergency Services: A Wake-up Call

Over the last decade, even with the additional prevention/intervention and full service partnership funding through the MHSA funding stream, there has been a dramatic rise in the number of patients accessing Psychiatric Emergency Services (PES). This is ground zero for crisis and the Contra Costa County behavioral health system barometer. It has reached a breaking point.

The average number of patients being seen in PES now averages nine hundred per month. This includes one hundred to one hundred and fifty children and adolescents per month. The PES physical plant is designed for fourteen to twenty patients; however, it routinely holds double this amount -- thirty to forty patients. This number had already sharply increased before the Affordable Care Act became operational and has not subsided with integrated services in several of our county health and mental health centers. While there was hope that the Miller Wellness Center would relieve the stress on PES, this has not occurred.

Behavioral Health Administration points out the pressing need for access to key outpatient services that are critical for discharge planning from both PES and the inpatient unit of the hospital (4C). These services include active case management, adult mobile response teams, drop-in services (e.g. a sobering center), and dual diagnosis treatment. It is essential to expand capacity for moderate to severely impaired mentally ill patients in behavioral health clinics while at the same time increasing psychiatric support for primary care providers so that stable patients in the behavioral health clinics may be transitioned to primary care providers.

The Impact of Chronic Understaffing

Each of the Children and Adult Specialty Mental Health Clinics are understaffed. The East clinic, for example, is operating with a deficit of three psychiatrists. At the adult clinics, a patient seeking psychiatric services may have "rapid access" to having a file opened, but the intake including the psychiatric evaluation and necessary treatment is delayed for two to four months. Children are seen for an intake appointment within ten days, but it may take two to three months for an initial psychiatry appointment. Patients have no other option but to access PES or the Miller Wellness Center. In order to provide needed care and prevent unnecessary hospitalizations, the clinics must maintain sufficient staffing levels. This is the first step in fighting the firestorm of over 900 patients that request treatment at PES each month.

This chronic understaffing is not a human resource problem. It is a failure to think creatively and to raise the level of pay to attract quality psychiatrists. We need to review the entire compensation packet for this pivotal position to see if we are aligned with other Bay Area counties. If not, we need to make competitive compensation a top priority.

Miller Wellness: Filling In For Clinics

The Miller Wellness Center Behavioral Health was intended as a Mental Health Urgent Care for patients with mild to moderate mental health conditions for up to 60 days, and a possible preventative service for voluntary-only severely mentally ill or severely emotional disturbed patients presenting at PES. It is not a specialty mental health clinic, and it cannot replace the psychiatric evaluations that are deemed medically necessary for disabled, severely mentally ill patients. Due to the markedly reduced access to mental health services through the county clinics, Miller Wellness Center has become the substitute for the behavioral health clinics, serving the moderate to severely impaired mentally ill population for substantially longer than the originally intended sixty days.

Providing For Family Support

Providing adequate support for families of both children and adults can also help prevent the avalanche of patients now being seen at PES. The Family Partner positions must be fully funded in each Children's Clinic and the Family Service Coordinator positions that have remained unfilled for five years must be filled in each of the Adult Clinics. These positions ensure that the families of seriously mentally patients can be educated to give vital information to health care professionals. They also support continuity of community-based and home care. These front line positions are essential and have remained unfilled for years, leading to crisis management in higher, more expensive levels of care.

Caring For Our Children

Since the AB 3632 mandate was suspended in 2011, severely emotionally disturbed children have been known to spend more than the statutorily allowed twenty three hours at PES waiting hospitalization or residential placement. Some children have spent months in PES awaiting an inpatient or residential placement. This puts additional stress on the patient and the staff. While this is a statewide and national problem, we have a legal and moral obligation to ensure the development of appropriate in-patient resources and facilities. Currently, freestanding hospitals are able to deny admittance to our most difficult young patients. Appropriate contracts need to be in place for high risk, difficult-to-place youth. The children's mental health clinics must be restored to the previous staffing levels of 2008. All front line positions should be filled, especially psychiatrists, nurses, and clinicians in order to alleviate the crisis. The Behavioral Health Administration also sees a great need for additional night and weekend clinics to augment the Miller Wellness Center and PES.

The county needs to work closely with First Hope to make a First Break program available for children and youths who are experiencing the initial effects of psychosis. This is one example of why it is essential to keep the "lists" open for hiring mental health specialists. Closing the list (as mentioned in the CAO handout on the Budget) prevents our clinics and hospital from acquiring the best and the brightest new graduates in the fields of Psychiatry and Psychology. Creative solutions such as internship programs with UC Davis and UCSF should be explored.

Housing That Heals

The number of persons with a serious mental illness who are homeless and in county shelters is rising. All MHSA-funded supportive housing for those with a serious mental illness is at capacity and our in-patient psychiatric unit is full. There is tremendous unmet need for mental health residential treatment and long-term supportive housing, yet we are holding millions of dollars in unspent MHSA funds.

More alternative treatment residential programs that lead to permanent, service-enriched housing models for people with serious mental illness need to be explored, invested in, and implemented. Although "Housing First" was been adopted and promoted in our county several years ago, it cannot be effectively implemented without an adequate inventory of housing that is embedded with services that support consumers in developing skills to maintain their health and recovery. A true supportive housing model that includes teaching many consumers "direct skills" to maintain their health and recovery will prevent many high costs and reduce out-of-county placements.

The housing needs of our consumers and families present many challenges that follow a continuum from least restrictive to locked settings. Some see a need for more permanent supportive and shared housing; others see a need for more shelters; while others are calling for more residential alternative treatment settings. There may be a need for all. Behavioral Health is committed to working with stakeholders to look at the whole picture and to define solutions to the housing crisis, but planning meetings without action plans that are implemented remain only a dream, not a needed solution.

Creating a well-planned system for moving those with serious mental illness into the most appropriate housing model will be a savings to the county. There will always be a need for locked facilities and skilled nursing facilities, but many patients could be more effectively served in alternative residential treatment programs and permanent supportive housing in this county. Permanent supportive housing will also give those living in shelters or transitional housing a better path to optimal health. The county budget process must take a deep look at the funding streams that could make supportive housing a reality for people with serious mental illnesses.

Funding Our Solutions

Although the above problems can be classified as "Quality of Care" or "Human Resource" issues, in reality they are "Budget" problems. They are local, state and national problems that we must tackle. They are not problems without solutions. Creativity and collaboration must be employed to use the various braided budget streams to protect and augment resources. Budgets must be built based on program needs defined by people in the trenches rather than generated by a formulaic, top down process that is not always sensitive to the harsh realities on the ground.

California has more mental health funding available than any other state in the union. Yet we do not demonstrate the best outcomes for our communities. While Contra Costa County has the tools to create the best mental health system in the state, we must break through bureaucratic and budgeting barriers in order to maximize our strengths. Funding must be allocated to meet patient needs at the clinic level and every level along the continuum of care. This will create fiscal and human savings because we will be treating illness before it enters the critical or crisis state. We have learned to do this routinely with heart disease, lung disease, cancer, and diabetes. Why not with the brain disease of mental illness?

Respectfully submitted,

Contra Costa County Mental Health Commission
In collaboration with the *Behavioral Health Administration*
And in consultation with the *Behavioral Health Care Partnership*

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APPENDIX
Source Reports and Articles to Consider

Financing mental health care
http://dover-files.com/66/A-Model-for-California-Community-Mental-Health-Programs.pdf
A report prepared in 1981 (still relevant today) at a time when legislature was aware of the underfunding of community mental health and asked the community to develop a report estimating how big the underfunding was and what would be needed.

http://www.mhac.org/pdf/mh_funding.pdf
Underfunded from the Start-2000-2001

http://histpubmh.semel.ucla.edu/sites/default/files/story-flipbooks/funding_publicmental_health/files/dmh_funding.pdf

www.chcf.org/.../download.aspx?id...
Public Mental Health Delivery and Financing in California

The lack of hospital beds; impact on Psychiatric Emergency Services
http://www.treatmentadvocacycenter.org/storage/documents/the_shortage_of_publichospital_beds.pdf

http://www.medpagetoday.com/Psychiatry/GeneralPsychiatry/44008

http://www.psychiatrictimes.com/psychiatric-emergencies/dearth-psychiatric-beds?GUID=EB5182F5-3FB6-4E50-A0B8-3E20501364F7&rememberme=1&ts=27022016

http://www.modernhealthcare.com/article/20131116/magazine/311169992

The rapid rise of Psychiatric Emergency Services
http://www.psychiatrictimes.com/psychiatric-emergencies/rise-emergency-psychiatry/page/0/1

Rise in Latino youth hospitalizations; comparative numbers for other youth groups
http://californiahealthline.org/news/latino-youth-in-california-see-significant-rise-in-psychiatric-hospitalizations/

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