

MENTAL HEALTH CRISIS INTERVENTION SERVICES

...SACRAMENTO COUNTY'S SHAMEFUL LEGACY OF NEGLECT

SUMMARY

Suicide rates are up, inmates at the jail with mental illness have doubled, hospital emergency rooms are overwhelmed and police officers are diverted off the streets to deal with mental health crises; all attributable to County decisions. The Grand Jury was appalled by the continued neglect and lack of action that Sacramento County has shown in dealing with their mental health crisis response system failings.

Untreated mental illness can have devastating consequences for individuals, family members and the community as a whole. Research has shown that failure to address mental health needs can increase the risks of homelessness, unemployment, family dysfunction and criminal justice involvement.

Every day we see or read about the impact of inadequate treatment in our community, whether it is persons with mental illness on the street, reports of self-injurious behaviors, tragic suicides or violence directed at family or others. The social and economic consequences of untreated mental illness are staggering. Thus, it is incomprehensible how Sacramento County would neglect and continually ignore those most in need of treatment.

Since 2009, persons with an acute mental health crisis have not been able to access services from an available Sacramento County crisis program. The costs to the community have far exceeded the money saved by program cuts. However, Sacramento County's decisions not to fund crisis services are more far-reaching than just budgetary cuts. The Grand Jury investigation has revealed the economic impact, the public safety impact, the health care impact and, most of all, the tragic personal toll that this lack of services has caused.

The Grand Jury found a continuing pattern of troubling decisions, starting with the Board of Supervisors' decisions to close the Crisis Stabilization Unit and reduce acute-care hospital beds by **50%** in the 2009-2010 budget. Despite ample and well-articulated warnings from departmental mental health staff, providers and community advocates of the dire consequences of the FY 2009-2010 proposed Mental Health budget cuts, Sacramento County all but eliminated crisis intervention services. Those budget decisions did not make sense then, and the failure to rectify the damage caused by those decisions at any time since then, makes no sense now.

The County, for over five years, has continued to abdicate responsibility for mental health crisis services, especially to low-income and indigent residents suffering from serious mental health disorders. Reviewing the County's decisions regarding the provisions of mental health crisis services over the past five years, the Grand Jury has seen little progress in resolving these serious problems. These actions have destabilized our mental health delivery system and caused major disruption in crisis care.

By their actions, Sacramento County:

- Shifted the primary responsibility for crisis intervention to community hospitals and law enforcement.
- Continued to provide inadequate funding to restore needed hospital and long-term care beds.
- Failed to capitalize on opportunities to restructure their mental health system to be more cost-effective, efficient and responsive.
- Forced law enforcement to take individuals involuntarily detained due to mental crises to area emergency rooms, substantially reducing the time that they could spend on patrol.
- Failed to maximize a variety of funding and revenue sources including grants, Medi-Cal reimbursement and Proposition 63.
- Created a worsening long-term drain on County financial resources.
- Damaged relationships and trust among the community, law enforcement and health providers.
- Generated lawsuits that successfully challenged the County's denial of basic mental health services.
- Created a situation where there are no County crisis stabilization services available to the public and law enforcement.
- Negatively impacted patient care:
 - In 2010, the year following the County cutbacks, the suicide rate spiked by **16%** (California Department of Public Health).
 - Since 2009, jail inmates receiving a diagnosis for mental disorders doubled (**18%** to **34%**).
 - There is a revolving door of patients with mental disorders continually recycling through the mental health crisis system. For example, last year only **16%** of patients at the intake stabilization unit were first time admissions.

There have been no discernible substantive efforts by the County to assume responsibility for the crisis programs or to initiate alternatives, in spite of the lawsuits, reports, independent findings and community concerns. The burden continues to fall on law enforcement, hospital emergency rooms, underfunded community programs, and most of all, on families and patients who are in crisis.

The Grand Jury's investigation explored a wide range of issues related to these budget cuts. Six months of research, interviews and extensive document review provided ample evidence of the need for the County to move quickly to establish an integrated crisis treatment capability.

The Grand Jury is recommending a series of actions, which, if adopted, can start the rebuilding process. A summary of these recommendations includes:

- Sacramento County needs a coherent, coordinated and cost-effective mental health system embodying early intervention and continuity of treatment at therapeutically appropriate levels of care providing more efficacious outcomes at lower costs.
- The County needs to provide timely crisis management response and to re-establish 24-hour intake, evaluation and referral programs similar to the level of services provided prior to the 2009 cutbacks.
- The County needs to immediately support and develop programs that use levels of care that avoid expensive and often unnecessary acute hospitalization. When hospitalization is required, it should be in facilities eligible for Federal reimbursement. Expanding the number of Psychiatric Hospital Facilities (PHFs) is an essential component for cost containment. Fostering greater use of residential treatment and skilled nursing facilities also provides more appropriate care settings at a lower cost.
- Sound County mental health programs cannot exist in a vacuum. Establishing trust and respect between the County and mental health professionals, law enforcement, hospitals, community providers, patients, advocates, and families will require coordinated and collaborative decision-making and should be a high priority. The County has opportunities to optimize the funding of the mental health system. Increased Medi-Cal revenue and Proposition 63 fund availability coupled with a restructured mental health system should provide greater long term stability.

The County mental health system must be organized so that it flows more smoothly from screening to hospitalization to discharge. A problem in any part of that continuum creates inefficiencies, unnecessary expenses and inadequate treatment. Sacramento County has problems in all three areas, and all three systems need to be addressed in order to make the mental health system more functional. The Grand Jury cannot overstress the interrelatedness of these issues of crisis, hospitalization, long-term care and lack of community resources pre and post hospitalization.

Sacramento County must accept responsibility that their mental health system has been fundamentally damaged by poor decisions and neglect, and will only be repaired when the County acknowledges and prioritizes the importance of mental health services. This is not just a budget issue but an issue of planning, programming and leadership to create a functional, responsive and effective mental health system.

BACKGROUND

The Grand Jury investigation of the County's mental health crisis response system was generated after hearing numerous complaints from hospitals and law enforcement about a problematic and non-responsive County mental health system. There were critical articles in the news media and there appeared to be increasing evidence of a dysfunctional system in our communities and on the streets. These factors led the Grand Jury to initiate a full investigation of the Sacramento County mental health crisis and hospital programs.

At the end of the last decade, California and the nation were experiencing a deep and prolonged fiscal crisis. State and local budgets were severely compromised and very difficult decisions

needed to be made. Sacramento County chose to make budget cut decisions in mental health by eliminating crisis services and dramatically reducing hospital bed availability. The effects of this fiscal crisis were expressed and reflected in the FY 2009-2010 budget. While there were dire warnings and ample concerns about the potential ramifications of the proposed cuts, Sacramento County implemented a series of reductions that have continuing and lasting negative impacts on the entire mental health system.

The magnitude and nature of the cuts were so severe and impactful that the mental health staff, law enforcement, local hospitals and the community expressed their alarm. The California Department of Mental Health sent formal letters expressing concerns that Sacramento County was failing to meet statutory requirements. A lawsuit was filed regarding the failure to provide crisis hospital services. Another lawsuit was filed regarding process and implementation of these cuts. The current Grand Jury found that the issues and concerns so frequently expressed had not been addressed despite an improved fiscal picture five years later.

Welfare and Institution Code 17000 statutorily requires counties to provide health care and emergency services to the medically indigent population and to act as a safety net provider. Sacramento has repeatedly chosen not to provide mental health or crisis services to the low-income and indigent population, even though they are County residents. Federal law and California's regulations regarding Medi-Cal programs require counties to provide mandated hospital and crisis services for the mentally ill in order to be eligible to receive any Medi-Cal dollars. Sacramento County was sued for their failure to provide hospital services, and settled the lawsuit by agreeing to pay for hospital services for Medi-Cal eligible individuals but not for indigent care.

A decision was made by the County in 2009 to eliminate the Crisis Stabilization Unit (CSU) to adults and reduce by 50% the inpatient bed availability at the Sacramento County Mental Health Treatment Center (SCMHTC). At that time the SCMHTC was averaging over 100 hospitalized patients a day and the CSU was experiencing over 6800 adult crisis visits a year. With these reductions there were no plans for any County crisis stabilization. The County only had plans for minimal contract hospital beds to be added.

This is not a new problem. The 2009-2010 Sacramento County Grand Jury identified some of these same concerns in their report, "A System in Crisis," calling for immediate County action to address these serious system failures. As part of the 2010 lawsuit, the County was required to hire an outside expert to assess the adult mental health program. That report, The Independent Expert Review Final Report, issued in May 2011 was very critical of the Sacramento County mental health crisis system and offered many recommendations that were well-reasoned, cost-effective alternatives to the current system. Only a few of those recommendations have been implemented.

The current Grand Jury tracked the consequence of Sacramento County's decisions. Findings and Recommendations from the Grand Jury's subsequent investigation are set forth in the following report sections.

METHODOLOGY

This investigation spanned a significant cross-section of the mental health environment. The Grand Jury performed the following activities and research during this investigation:

INTERVIEWS

- Senior management of community hospital systems including Kaiser Permanente, University of California - Davis Health System, Dignity Health and Sutter Health
- Law enforcement officials representing the cities of Sacramento, Folsom, Elk Grove, Citrus Heights and the County
- Senior managers from Sacramento County Behavioral Health (past and present) and senior management from the Sacramento County Health and Human Services Department

RECORDS REVIEWED

- Financial and budgetary records, including FY 2007-2008 to the present, encompassing mental health budgets, cost reports, revenue, expenditure and accrual information, and program and fiscal audits
- Bed utilization documents for 24-hour bed utilization statistics:
 - State hospital contract beds
 - Sacramento Mental Health Treatment Center beds
 - Institute for Mental Disease contract beds
 - Contract inpatient beds and crisis residential beds
 - 23-hour crisis utilization
- Related correspondence, memos, analysis for Sacramento County Mental Health Center bed reduction and emails:
 - Crisis Stabilization Unit closure, Proposition 63 (Mental Health Services Act) budgets, expenditures, allocations, prudent reserves
 - Senate Bill 82 (Mental Health Wellness Act) grant applications and funding
 - Correspondence, memos, analysis and emails related to the current SCMHTC plans; Sacramento County Mental Health funding categories, i.e. Medi-Cal, indigent, insured patient population by year; and number of Murphy Conservatees and Incompetent to Stand Trial (Penal Code 1370)
- Additional information was reviewed from research articles and publications and a partial list is provided in Appendix C.

DISCUSSION

Due to the complexity of the issues surrounding this investigation, the foregoing discussion is organized to correspond to the Grand Jury's formal Findings presented toward the end of this report. Most of these problems are inextricably interrelated and, as such, should not be addressed or considered solely on their own.

Sacramento County has abdicated the provision of crisis services for the mentally ill. The current mental health crisis services in Sacramento County are inadequate, anti-therapeutic, costly and dangerous.

Prior to 2009 the Crisis Stabilization Unit (CSU) and the Sacramento County Mental Health Treatment Center (SCMHTC) served as the centralized point of intake for crisis treatment for the County. Both law enforcement and the community knew that in any mental health crisis there was around-the-clock availability for crisis screening and issue resolution, including hospitalization at the Stockton Boulevard facility. In the FY 2009-2010 mental health budget, Sacramento County, based on severe fiscal constraints on National, State and local budgets, eliminated the CSU and reduced capacity at the SCMHTC by 50%, even though there were ample credible warnings of the dire consequences of this decision.

In a formal presentation to the County Board of Supervisors, County Behavioral Health administrators warned that the proposed budget actions would have profound consequences. The warnings given to the Board prior to the adoption of the ordered budget cuts had merit then and still resonate:

“Impacts of Reductions to Law Enforcement

- *Place a greater burden on law enforcement to find placement for mentally disordered persons (5150)*
- *Increase number of psychiatric patients entering jail system*
- *Increased volume of court cases*

Impacts of Reductions to County Government

- *Increase of liability risk to County*
- *May not meet minimum requirements for State Regulations for funding of Mental Health Plan (e.g., serving all Medi-Cal patients)*
- *Risk of losing Mental Health Realignment allocation if unable to meet Mental Health Plan Contract with State*

Impacts of Reductions to Community

- *Increased number of psychiatric patients in local emergency rooms thereby decreasing number of available beds for medical patients*
- *Shifts costs of emergency psychiatric treatment to local hospitals*
- *Increase psychiatric homeless population*
- *Radically reduce acute care services in Sacramento County*
- *Increase in completed suicides”*

The presentation to the Board of Supervisors about consequences of the cuts was prophetic and, in reality, the outcomes have worsened with time as the Grand Jury has found:

Impacts of Reductions to Law Enforcement

- Virtually overnight law enforcement was required to transport persons in mental health crisis, 5150 holds, to area emergency rooms (ERs) rather than to a more therapeutically appropriate, available and less costly County Crisis Stabilization Unit. These patients are required to be medically evaluated, including an exam and laboratory tests, incurring unnecessary and wasteful costs.
- Sheriff's deputies and police officers were forced to spend extra time in the ERs until patients on 5150 holds could be medically assessed. This extra time spent in the ERs detracted from time on patrol at a time when the law enforcement had already incurred substantial personnel cutbacks.

Impacts of Reductions to County Government

- The County was served with several lawsuits challenging their decision to reduce mental health outpatient services as well as for failure to reimburse private psychiatric hospitals for County Medi-Cal patients. While the cutbacks in outpatient mental health services are not addressed in this investigation, it is referenced since it speaks to a pattern of unwillingness or inability to implement recommendations that could provide more cost-effective treatment options.
- A lawsuit stemming from the earlier action eliminating contracts with private psychiatric hospitals against the County, BHC Sierra Vista Hospital, Inc., and BHC Heritage Oaks Hospital Inc. v. County of Sacramento et al. (*BHC v. County*), centered on the County's failure to reimburse private psychiatric hospitals for care rendered to Medi-Cal mental health patients admitted as emergencies.
- In 2009, the California Department of Mental Health legal department wrote a letter raising serious concerns about Sacramento County's failure to provide statutorily required hospital and crisis services to Medi-Cal eligible residents.
- A second lawsuit, *Napper v. County of Sacramento*, was filed asserting that some of the mental health cuts were illegal.

Impacts of Reductions to Community

- Hospital ERs, already stretched to capacity, were now forced to revamp their facilities in an attempt to isolate 5150 patients from other patients with medical emergencies. Millions of dollars were spent to enhance internal security and to absorb additional losses for uncompensated care.
- Mental health services provided by local private contractors were eliminated or greatly reduced. County employees displaced by the closure of the CSU and the reduction in SCMHTC beds were transferred to fill positions previously occupied by the private contractors. Testimony offered by present and former department officials differed with respect to the cost-effectiveness and work quality of replacing the private contractors with County employees.

- Despite large budget cuts eliminating services, the final 2009-2010 department budget only reduced the total approved County mental health positions by 1.5 full-time equivalents out of about 352 personnel.
- In 2010 there was a significant spike of **16%** in suicide rates in Sacramento County, as reported by the California Department of Public Health.

Sacramento County's decision to close the Crisis Stabilization Unit to adult patients and to eliminate 50 beds from the Sacramento County Mental Health Treatment Center had widespread negative fiscal consequences.

The decisions reducing the Behavioral Health budget by approximately \$14,000,000 had a profound impact on a wide array of services and the community at large as mentioned in the previous discussion:

- The County settled the private hospital lawsuit by paying \$3,000,000 in back payments and agreed to pay a higher \$950 per day rate for Medi-Cal patients at these hospitals.
- Hospitals had to hire additional professional staff to deal with the unique characteristics of this population.
- Hospitals had to hire or contract for added security.
- Hospitals had to develop and fund referral resources, including residential treatment, on their own.
- Law enforcement had to spend more time on psychiatric emergencies requiring a redirection of resources.
- The Sheriff's Department had to provide more mental health services in the jail.
- Increased Medi-Cal eligibility, due to the Affordable Care Act (ACA), increased the County's financial liability at the private psychiatric hospitals.

An unintended impact on the court settlement agreeing to pay a higher per diem rate for Medi-Cal patients was the implementation of the Affordable Care Act (ACA). Patients previously determined to be low-income or indigent are now granted immediate Medi-Cal eligibility under a presumptive eligibility provision. Due to the 2010 settlement, the County must now pay higher costs based on the inflated negotiated daily rate for an escalating number of Medi-Cal recipients. Although the terms of the lawsuit settlement ended during 2014, the County agreed to continue paying the same higher rate. The County has thus far been unable to negotiate a lower rate.

The inpatient fiscal liability would be worse were it not for a Congressional pilot waiver program negotiated by Congresswoman Doris Matsui (Matsui Waiver) to allow Federal dollars to pay for acute inpatient stays at non-governmental hospitals classified as Institutions for Mental Diseases (IMD). Sacramento County was one of two California counties to participate in the pilot program. This participation and subsequent funding has saved millions of dollars for the County, and is scheduled to expire in July, at the end of the current fiscal year.

The Mental Health Department has gone back to the Board of Supervisors asking for significantly more money to fund this shortfall. If the Matsui Waiver is discontinued, the budgetary impact to the County will be even greater. That possibility alone should be sufficient emphasis to undertake system-wide changes.

With increased eligibility and Federal matching funds, the County has added opportunities to receive reimbursement for treatment services. When the County closed the CSU to adult patients in 2009, the County estimated that they would lose approximately \$2,500,000 in annual revenue from Medi-Cal. With the continued closure of the CSU, the County has lost opportunities to capture significant revenues.

As discussed in previous sections of this report, the County's failure to either utilize or have in place less expensive alternatives to inpatient hospitalization only exacerbates its fiscal liability. A comparison is provided of the daily cost for acute mental health hospitalization:

Sacramento County Mental Health Treatment Center	\$1,325
State Hospitals	\$646
Psychiatric Hospitals (negotiated rate)	\$950
Sacramento County PHFs	\$653

While the differences in hospital costs are significant, the potential savings to the County by better use of appropriate therapeutic levels of care are demonstrated by the costs of skilled nursing facilities (SNFs) that range between \$181 and \$225 per day in the Sacramento region. Another cost-effective alternative is the expanded use of residential treatment facilities that offers another potential for savings.

The high level of the cost of care rendered at the SCMHTC merits reexamination. In order to receive Federal reimbursement for mental health hospital treatment, the care must be rendered in an inpatient facility that offers a full array of hospital inpatient services; SCMHTC is not eligible for Federal reimbursement. To enable the County to receive Federal matching funds for SCMHTC patients, an option would be to pursue an arrangement transferring the SCMHTC to the University of California, Davis Medical Center. Other alternatives are also worthy of serious exploration.

Best practices and evidence-based solutions provide many examples of programs reducing the overall cost of crisis care by lessening the intensity and the severity of otherwise costly mental health crises and/or hospitalizations. A summary of some widely accepted best practices is contained in Appendix B.

Investing in programs providing long term solutions costs money. Testimony, however, indicated that the County has been overly cautious in seeking funds from various grant programs established specifically to kick-start a wide array of mental health treatment programs. Best practices and a review of research material indicate that patients are placed in the appropriate levels of care and are given the treatment appropriate to their condition, further providing long-term cost savings when compared to a system with limited scope.

Sacramento County's shift of responsibility for crisis services has overwhelmed community hospital emergency rooms.

Hospital ERs have had to assume a disproportionate share of the responsibility for this segment of the population. These overwhelming challenges to hospital ER professionals have included access to appropriate services, lack of treatment alternatives, knowledge of and access to previous psychiatric history within the County's treatment system, as well as ongoing communication difficulties with the County.

Prior to the closure of the CSU, law enforcement officers brought patients on 5150 holds to the CSU and were then able to drop them off. The CSU had 6869 admissions in the year prior to closure. These admissions were a combination of walk-in and law enforcement referrals. In 2013, more than 15,600 patients, or over 1300 per month, were taken to hospital ERs in mental health crisis. In 2014, this number had increased to an estimated 1400-1500 per month.

The majority of these patients were brought in for mental health reasons without presenting problems requiring medical attention. According to several community hospital officials, patients are often subjected to unnecessary, invasive and expensive screening and testing because the County or the private psychiatric hospitals require these tests.

With limited bed availability in stand-alone psychiatric hospitals, mental health patients admitted through the community ERs can remain on a gurney in hospital hallways for 18 to 30 hours, and sometimes longer, waiting for a bed. During these extended times in the emergency room sometimes the crisis abates without treatment and these patients are no longer deemed to be a threat to themselves or others, and then must be discharged, because legally they can no longer be confined.

Community hospital representatives who were interviewed were unanimous in their opinion that ERs are not the appropriate therapeutic venue to deal with patients whose primary issues may be psychiatric, often coupled with co-occurring substance abuse problems.

One very serious concern for ERs is the cost to provide additional security to deal with the increase in violent behavior exhibited by mental health patients. Hospitals must either employ their own security personnel or contract with local law enforcement. Even with increased security, injuries to hospital staff have risen.

A significant portion of mental health patients are not receiving appropriate treatment for their mental health issues, creating a situation where many of these individuals are repeat patients. This reflects either inadequate previous hospital treatment and/or a current lack of community resources to deal appropriately with the needs of these mental health patients.

The lack of crisis intervention services and adequate community programs can have a negative effect on the recovery of individuals. In the 2013–2014 fiscal year, only **16%** of individuals referred to the intake stabilization unit were discharged to the community as compared to **46%** before the cutback in services. This suggests that individuals were not receiving the treatment that they needed and that crises escalated to the point of hospitalization; or that there were inadequate community resources available.

Previously, the gatekeeping function of the CSUs prevented unnecessary hospitalizations, resolving mental health crises more quickly and with better outcomes than sending them to local ERs. Without any County gatekeeping, the impact on community hospitals is undeniable.

Sacramento County's shift of responsibility for crisis services has adversely impacted area law enforcement agencies.

Equally disturbing is the effect that the County's decisions have had on area law enforcement. Currently, under Police Officers Standards and Training (POST) requirements, police academies need only to provide six hours of initial training on mental disorders and strategies for dealing with individuals in crisis. Law enforcement agencies are beginning to offer Crisis Intervention Training

(CIT) in both 8 and 24 hour courses that offer more in-depth information, strategies and techniques for handling individuals in crisis. Enhanced training comes from the recognition that law enforcement is now increasingly required to make assessments of mental health issues.

Law enforcement had asked for more mental health training and requested funds from the County to develop more mobile crisis teams and CIT utilizing Proposition 63 dollars. Unable to obtain any funding from County Mental Health and realizing this crucial need for training to deal with patients with mental disorders, the Sheriff's Department independently obtained a CIT grant. Recently, a Senate Bill 82 grant has partnered County Mental Health and two area law enforcement agencies in pilot mobile crisis programs.

Between 2008 and 2014 the Sacramento County population increased by less than **10%** and the number of mental health crisis calls to law enforcement dispatchers in three jurisdictions collecting this data reported increases averaging **29%**.

During the same time period, five law enforcement agencies reported that the number of individuals detained on 5150 holds increased by **8%**.

The increase in mental health 5150 holds would have been significantly greater were it not for a sharp decrease in the number of holds recorded by the Sacramento County Sheriff's Department in 2014. The Sheriff's office believes that this decrease could be attributable to the CIT provided to deputies in late 2013 and throughout 2014. The reduction of 305 fewer holds over the last year, suggests the potential cost savings from this type of program. Prior to this enhanced training, 5150 holds increased an average of **12.4%** in the County.

A lack of community resources may affect how law enforcement personnel handle the disposition of persons exhibiting inappropriate or unstable behavior. This scenario was particularly evident in the year immediately following the closure of the Crisis Stabilization Unit: between the City of Sacramento and the Sheriff's Department, service calls increased **4.5%**, yet the number of 5150 holds correspondingly decreased by **30%** and **51%** respectively.

Given the lack of community treatment options, it is not surprising that the Sheriff's Department reports that the incidence of significant mental health disorders among inmates has increased from **18%** prior to the cutbacks to the current rate of approximately **34%**.

Available data clearly shows that the problem of mental health crisis calls is worsening. In response, law enforcement has had to look for other alternatives to better deal with their increased mental health crisis responsibility.

Sacramento County's use of inpatient hospitals is dysfunctional and currently too expensive.

Sacramento for many years has relied on the Sacramento County Mental Health Treatment Center (SCMHTC) to provide adult acute psychiatric hospital care. In 2008, responding to budget constraints, Sacramento County eliminated its contracts with private freestanding psychiatric hospitals for inpatient mental health services. Then in 2009, the County eliminated 50 of the 100 SCMHTC beds. These severe reductions created an acute psychiatric bed crisis. Prior to the bed reduction, SCMHTC was already exceeding its legal capacity by almost **10%** each day. When the County made bed reductions they had no adequate replacement plans in place for this at-risk population. Almost immediately after these cuts, the California Department of Mental Health sent

a letter to Sacramento County stating that the County appeared not to be in compliance with California and Federal Medicaid requirements.

A legal challenge to the County's refusal to pay private psychiatric hospitals for care provided to Medi-Cal and indigent patients, resulted in a settlement, *BHS v. County*, assuring that the County would be responsible for payment for Medi-Cal clients admitted to several local private psychiatric hospitals. As part of the settlement, the County agreed to pay an inflated \$950 daily rate. On face value the higher rate is unsupported by payments made to the other Sacramento psychiatric hospitals. One explanation provided to the Grand Jury for the higher settlement rate is that the FSHs also agreed that the County would not be liable for care provided to indigent and low-income adult mental health patients if they were accepted for admission.

In this settlement, the County assumed no responsibility for indigent care costs at the hospitals. It appears to the Grand Jury that this settlement provision echoes a pattern of refusing to accept program and fiscal responsibility for mental health crisis and hospital care for low-income and indigent patients.

At the time of the cutbacks, SCMHTC was not eligible to receive Medi-Cal reimbursement, while small 16-bed or less psychiatric hospitals could be deemed eligible. In 2010, Sacramento County contracted with Crestwood, a private facility contractor for the development and operation of two 16-bed Psychiatric Health Facilities (PHFs), one of which opened in 2010 with 12 beds and added 4 additional beds the following year. A second 16-bed unit was also opened the following year.

By the end of 2012, including the 50 SCMHTC beds, the County had a total of 82 acute mental health inpatient beds, far fewer than were needed in 2008. These PHF beds are currently filled to capacity 100% of the time indicating the need for additional beds, especially those eligible for Federal reimbursement.

While the SCMHTC is not currently eligible for Federal reimbursement, the County should explore options for better utilization of that facility. There are 50 beds at SCMHTC not being utilized and which could not be reasonably replaced if they are eliminated, a renovation that the County is actively pursuing. There must be a thoughtful analysis of all the alternatives for SCMHTC, including expansion. For example, SCMHTC could become a resource for indigents needing hospitalization, it could be converted to a long term care facility, or there could be a complete transfer of administration or ownership of the facility to gain potential eligibility for reimbursement under Medi-Cal.

The community hospital emergency rooms are referring more patients for hospitalization. The 32 PHF beds are always filled and there are limited non-hospital alternatives. The SCMHTC is currently using **50%** of the 50 beds for non-acute patients. If there was a problem with inadequate bed availability in 2009, those inadequacies are even more pronounced today.

Sacramento County's relationship with hospital providers and law enforcement is strained or conflictual.

In interviews with the four community hospital systems and five law enforcement agencies, Grand Jury members repeatedly heard reports of conflicts in the relationship with Sacramento County Departments of Behavioral Health and Health and Human Services. Respondents offered unsolicited comments that their relationships with Sacramento County officials since 2009 were either strained, conflictual, poor or non-existent.

According to both medical providers and law enforcement, the problems associated with the closures can be divided into three categories: communication, shifting responsibility and shifting financial costs.

COMMUNICATION

- Both hospitals and law enforcement saw the closures as abrupt, with little prior warning, and with insufficient time to plan for the care of mental health patients in crisis. The community had inadequate information on where to go in a mental health crisis. The only instructions given to the community were to call 911 or to go to an ER.
- Emergency rooms were not prepared for the onslaught of patients. Words used by the hospitals during our interviews to describe the County's actions included "irresponsible," "unconscionable" and "non-responsive." Hospitals report that they continue to have difficulty working with the County to develop solutions to resolve this situation. Not only do hospital systems believe that the County is not cooperating in reducing long emergency room stays, but the hospitals also believe that the County is requiring unnecessary medical tests.
- The law enforcement community described the relationship with the County as "fractured," "opaque," "not helpful" and "unresponsive." Some in the law enforcement community maintained that there was little prior communication from the County on what the impact would be on law enforcement's added responsibilities concerning mental health patients. It should be noted that law enforcement reported that they had an excellent relationship with County Mental Health prior to closure of the Crisis Stabilization Unit. The decision to close the CSU was a critical changing point in the relationship.

SHIFTING RESPONSIBILITY

- Emergency rooms now have to do crisis and medical screening prior to intake stabilization unit acceptance. Hospital systems characterize the County's actions as a conscious shift of public responsibility to the private sector. They have been told by County officials that they must assume more responsibility for the mentally ill population. Hospital officials expressed their belief that the County had abdicated their responsibility for care and treatment of the mentally ill, adding to the tension.
- In 2010 three hospitals filed suit against Sacramento County for failure to meet the statutory responsibility for care of the mentally ill who needed hospitalization. The County settled this suit by agreeing to pay a higher rate for Medi-Cal patients' hospitalizations, while maintaining that they were not liable to pay for indigents' hospitalizations.
- Individuals in mental health crisis or their family members have been told to call 911 instead of a County mental health program. Prior to the reductions, patients and families in crisis could call the CSU or other mental health providers and would receive services that could often avoid hospitalization. The County's mental health providers were familiar with their patients and could better assess treatment options.
- As sole responders to increased 911 calls, law enforcement must now deal with more patients in mental health crises.

SHIFTING FINANCIAL COSTS

- All community hospitals have incurred substantial costs for crisis screening and testing, security and support professionals.
- Area hospitals have been warned by County officials that it is their responsibility to contribute to new mental health crisis program costs or the hospitals can expect a continuation of the current problems besetting their emergency rooms.
- Increasing 911 mental health responses have reduced law enforcement's ability to perform normal policing duties.
- Increasing numbers and the frequency of patients cycling through all these other systems that are not a part of the mental health continuum increases the cost to these other adversely impacted entities.

Sacramento County's use of long-term, non-acute 24-hour care utilization is inadequate, costly and fails to utilize more appropriate alternatives.

During the course of this investigation, it became apparent that there was a problem with the lack of availability of 24-hour care for individuals who do not need acute hospitalization. At times, acute hospital beds were filled with individuals who no longer needed that level of care, which prevented new admissions from being accepted. The genesis of the long-term bed availability was in FY 2008-2009 when there began a steady process of reducing long-term care bed contracts.

- According to bed utilization reports, during FY 2009–2010, Sacramento County was using **131** beds per day from a variety of providers [State Hospitals, Institutes for Mental Disease (IMD), and skilled nursing facilities (SNFs), etc.] for individuals with 24-hour care non-acute needs. Currently, the County is contracting for only **30** long-term care beds per day. It is not clear why this number has dropped, or whether those individuals are even receiving treatment.
- There is some evidence that the Proposition 63 programs have helped return some of these individuals from these long-term care facilities to the community. However, it does not appear that these programs can meet the needs of all individuals requiring longer term residential care.
- There are more individuals in need of mental health longer term treatment than resources available, and some of those individuals have complex placement needs.
- An indicator that needs are not being met is the fact that of the 50 beds available at the SCMHTC for acute hospitalization, almost **50%** are currently filled with non-acute patients awaiting placement. This utilization is problematic for several reasons, among them that beds are not available for acute admissions as well as being overly expensive.

While the shortage of appropriate long-term beds is one concern of the Grand Jury, another concern is the financial impact of the current pattern of utilization. Patients who are in the SCMHTC are currently costing the County **\$1,325** per day, which is not reimbursable by any other source other than County general funds. This is an exceedingly high rate to pay for individuals who do not need acute hospitalization. Daily costs for stays in State hospitals at **\$646** per day or a skilled nursing facility at **\$225** per day are drastically less. While stays in most long-term care facilities such as State hospitals and IMDs are not reimbursable by Medi-Cal, they are still

considerably less expensive than the acute daily rates at psychiatric hospitals and dramatically less than the SCMHTC.

Sacramento Mental Health officials report that there is a statewide shortage of appropriate long-term care options, and that this problem of placement is not unique to Sacramento County. Because of the issue of supply and demand, private contractors who provide long-term care have been able to be more selective about whom they have accepted for care. Since private providers are not accepting these patients with complex needs, the County should develop less expensive resources to provide these appropriate residential services.

Currently, patients who are in need of a lower level of care are often at SCMHTC where they are utilizing expensive acute hospital beds. A significant concern is that these non-acute patients inappropriately filling scarce hospital beds deny this resource to patients who need this level of care.

This inability to place acutely ill psychiatric patients has led to unacceptably long stays in emergency rooms, impacting services and care to other critically ill medical patients. This has a ripple effect on the whole mental health system because of the logjam created by not placing non-acute patients appropriately. There are models of best practices throughout the State of non-hospital alternatives that are less costly and more effective at moving patients to an appropriate level of care quickly. Data from the Urgent Care mental health program in Los Angeles County is an example of a program that provides strong support for alternative models of care.

IN CONCLUSION

The County mental health system must be organized so that it flows more smoothly from screening to hospitalization and to discharge. A problem in any part of that continuum creates inefficiencies, unnecessary expenses and inadequate treatment. Sacramento County has problems in all three areas, and all three system components need to be addressed in order to make the mental health system more functional. The Grand Jury cannot overstate the inter-relatedness of these issues of crisis, hospitalization, long-term care and lack of community resources pre and post hospitalization.

FINDINGS

- F1. Sacramento County has abdicated the provision of crisis services for the mentally ill. The current mental health crisis services in Sacramento County are inadequate, anti-therapeutic, costly and dangerous.
- F2. Sacramento County's decision to close the Crisis Stabilization Unit to adult patients and to eliminate 50 beds from the Sacramento County Mental Health Treatment Center, as well as subsequent program decisions, has had widespread negative fiscal consequences.
- F3. Sacramento County's shift of responsibility for crisis services has overwhelmed community hospital emergency rooms.
- F4. Sacramento County's use of inpatient hospitals is dysfunctional and currently too expensive.
- F5. Sacramento County's shift of responsibility for crisis services has adversely impacted area law enforcement agencies.
- F6. Sacramento County's relationship with hospital providers and law enforcement is strained or conflictual.
- F7. Sacramento County's use of long-term, non-acute 24-hour care utilization is inadequate, costly and fails to utilize more appropriate alternatives.

RECOMMENDATIONS

The Grand Jury's facts and findings provide ample evidence that the negative ramifications of prior policy decisions are widespread and complex. As such, the Grand Jury's recommendations span a wide array of options, some more critical than others. The following recommendations are numbered for reference only and do not connote any order of priority or preference.

SACRAMENTO COUNTY SHOULD:

- R1. Provide documentation that they are meeting all requirements for the provision of crisis and hospital services for the seriously mentally ill.
- R2. Establish a fully functional and available 23-hour intake and evaluation crisis unit (Crisis Stabilization Unit) or similar urgent care model.
- R3. Develop, expand and support outpatient programs that respond to and mitigate mental health crises before they escalate.
- R4. Expand mobile crisis programs.
- R5. Assure continuation of CIT (Crisis Intervention Training) opportunities for law enforcement by exploring all available funding options.
- R6. Expand crisis residential services, both acute and non-acute.
- R7. Maximize reimbursable services utilizing funding sources including Prop 63 (MHSA), S.B. 82 (Mental Health Wellness Act), and Medi-Cal.
- R8. Clearly articulate the County's budget for crisis and hospital services for non-Medi-Cal patients.
- R9. Involve the community in developing strategies regarding hospital bed availability, utilization and funding for patients requiring psychiatric inpatient care.
- R10. Cease the ongoing renovation project to convert the closed 50 beds at the SCMHTC and conduct an independent evaluation of cost-effective and highest use for this facility.
- R11. Use existing SCMHTC hospital beds for acute stays rather than for non-acute or administrative stays.
- R12. Consider additional 16-bed Psychiatric Health Facilities contingent on the analysis of an overall mental health crisis response plan.
- R13. Address the damaged relationships with community hospitals, law enforcement, and the mental health community at large.
- R14. Provide alternative longer-term 24-hour non-acute capacity that is less expensive than acute hospitalization.
- R15. Develop and implement programs for difficult to place patients.

RESPONSES

Penal Code sections 933 and 933.05 require that the following officials submit specific responses to the findings and recommendations in this report to the Presiding Judge of the Sacramento County Superior Court by October 1, 2015:

- Sacramento County Board of Supervisors - All Recommendations, 1- 15
- Director, Sacramento County Department of Health and Human Services - Recommendation 13

Mail or hand-deliver a hard copy of the response to:

Robert C. Hight, Presiding Judge
Sacramento County Superior Court
720 9th Street, Department 47
Sacramento, California 95814

In addition, email the response to:

Becky Castaneda, Grand Jury Coordinator at castanb@saccourt.com

DISCLAIMER

This report was issued by the Grand Jury with the exception of one juror who believed there might be a perceived conflict of interest. This Grand Juror was excluded from all parts of the investigation, including interviews, deliberations, and the writing and approval of this report.

APPENDIX A

GLOSSARY

Acute: when used in conjunction with hospitalization, hospital beds or a medical condition, refers to active but short-term treatment for a severe injury or episode of illness, an urgent medical condition.

Co-occurring: typically refers to an individual having co-existing mental health and substance use disorders.

Crisis Intervention Training (CIT): in both 8 and 24 hour versions, provides first responders with the tools to identify mental disorders, the communication skills to ensure the safest outcome for all involved, and information about community resources.

Crisis Residential Program (CRP): community-based treatment programs for adults experiencing a mental health crisis.

Crisis Respite: a home-like setting staffed around the clock, seven days a week, by counselors serving individuals or families experiencing a mental health crisis but who are not an immediate danger to self or others.

Crisis Stabilization Unit (CSU): an outpatient psychiatric service providing screening, assessment, and crisis intervention and medication management strategies for up to 24 hours for individuals suffering behavioral health crises.

Emergency Room (ER): a hospital room or area staffed and equipped for the reception and treatment of persons with conditions (illness or trauma) requiring immediate medical care. Also referred to as emergency departments (ED).

Fiscal Year (FY): any yearly period without regard to the calendar year, at the end of which a firm, government, etc., determines its financial condition. In Sacramento County it is July 1 to June 30.

Institutions for Mental Diseases (IMD): a hospital, nursing facility, or other institution of 17 beds or more that is primarily engaged in providing diagnosis, treatment, or care of people with mental diseases.

Involuntary Psychiatric Hold (5150): a section of the California Welfare and Institutions Code (WIC) which reads, in part, when a person, as a result of a mental health disorder, is a danger to others, or to himself or herself, gravely disabled, a peace officer, ... upon probable cause, take, or cause to be taken, the person into custody for a period of 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the county for evaluation and treatment and approved by the State Department of Mental Health Services.

Mental Health Service Act (MHSA) aka (Proposition 63): passed in 2004, taxes high-earning personal income with the money being used to provide dedicated funding for the expansion of certain mental health services and programs. These funds cannot be used for involuntary or hospital services.

Mental Health Wellness Act of 2013 (Senate Bill 82): established a competitive grant program to disburse funds to California counties or to their nonprofit or public agency designates for the purpose of developing mental health crisis support programs.

Non-acute: maintenance or care in which the primary clinical purpose or treatment goal is support for a patient with impairment, activity limitation or participation restriction due to a health condition.

Peer Support: individuals who have experienced mental disorders and who provide support, encouragement, hope, mentorship and assistance with linkage to mental health services.

Psychiatric Health Facility (PHF or PHF Unit): a facility for the care and treatment of patients affected with acute or chronic mental disorders. To qualify for Federal reimbursement a PHF must have 16 or fewer licensed beds.

Psychiatric Emergency Services (PES): an outpatient psychiatric service providing screening, assessment, crisis intervention, and medication management strategies for up to 24 hours for individuals suffering behavioral health crises.

Sacramento County Mental Health Treatment Center (SCMHTC): Sacramento County owned and operated hospital for the treatment of acute mental disorders.

Urgent Care, Mental Health: usually operated with extended hours to provide both emergency and non-emergency evaluation and treatment on a walk-in or appointment basis.

APPENDIX B

BEST PRACTICES

The term “best practices” describes innovative strategies and programs providing desirable outcomes in such areas as science, business, health care and manufacturing. In the field of mental health, the following best practices have provided proven, cost-effective and efficacious alternatives:

LAW ENFORCEMENT PROGRAMS

CRISIS INTERVENTION TRAINING

(CIT) was developed by the Memphis Police Department to assist officers in the field in facilitating the officers’ experiences in dealing with persons experiencing mental disorders and its interface with the criminal justice system. CIT is a structured educational program that has a series of classroom trainings and modules, workshops and role-playing activities that help the officers better understand how to make appropriate interventions in the field. This program has been widely disseminated and has been utilized throughout California by many law enforcement agencies.

MOBILE CRISIS

There are a number of programs throughout California that pair sworn peace officers with licensed mental health professionals to address crisis situations in the field. While there may be a number of variations of this program, for example PERT, MET, SMART, PET are common acronyms for these “emergency” response teams, all have the same guiding principles of law enforcement and mental health partnerships.

Mobile Crisis response programs have demonstrated a marked reduction in hospitalizations and serve to enhance the ability to provide appropriate services in the community through appropriate referrals. Sacramento County recently received a grant (SB 82) to develop this type of program with the Sacramento Police Department, the Sacramento County Sheriff’s Department and Sacramento County Behavioral Health.

MANDATED TRAINING

Currently peace officers are only exposed to a limited amount of training in understanding mental health issues in their initial POST (Peace Officer Standard Training) required training (8 hours). Best practices indicate that expanding the number of hours of exposure to training on mental health issues has an exponential effect on the efficiency in dealing with mental health situations in the community. Some Sacramento County Law Enforcement agencies have mandated further continuing education in mental health for their officers.

PSYCHIATRIC HOSPITAL PROGRAMS

ALAMEDA MODEL

Emergency Rooms and hospitals often cite the model of services provided in Alameda County and other similar county programs as a best practice. The John George Psychiatric Hospital in Oakland is a stand-alone psychiatric campus that is part of the Alameda County Health System. This facility

provides psychiatric emergency services and acute care services to adults experiencing severe mental health crises.

This program has dramatically reduced the amount of time that mental health patients are held in emergency rooms in Alameda County to less than two hours and has also been able to refer over 76% of the 5150 patients to community resources rather than hospitalization. This program is similar to the program that used to exist in Sacramento with the Crisis Stabilization Unit and the Mental Health Treatment Center on Stockton Boulevard.

COMMUNITY PROGRAMS

CRISIS STABILIZATION UNITS-23 HOUR (CSU)

These outpatient programs are very effective in accepting referrals of all who need some level of psychiatric care and who are in mental health crisis. Available 24 hours a day, seven days a week, these programs are staffed by trained multi-disciplinary health professionals. Often these programs are connected with a 24-hour acute care facility whether it is a freestanding hospital (FSH), a Psychiatric Health Facility (PHF), or an acute care hospital. These programs can be designated 5150 receiving facilities.

Statewide, these programs have shown consistent results in reducing hospitalizations, following through with appropriate community referrals. By working closely with law enforcement, the CSUs have diminished the length of time that law enforcement must be engaged at a mental health facility so that officers can return to the community to continue policing. These programs are characterized by their strong linkages to the community and their ability to provide appropriate referrals and arrange for follow-up. This was similar to the program that existed in 2008-2009 in Sacramento County.

MOBILE CRISIS

Mobile Crisis is a best practice program that consists of a mental health interdisciplinary team that is able to respond to a request for crisis intervention in the community. It differs from the law enforcement mobile crisis model that pairs a police officer with a mental health professional. These mental health field evaluations often can avoid hospitalizations, increase the possibility of appropriate referrals, and can de-escalate situations on a timely basis. It is not unusual for mobile crisis programs to have access to other community resources such as outpatient treatment or crisis residential services reducing hospital admission rates by 30-40%. These programs are eligible for MHSA funds, Mental Health Wellness Act funds (SB 82), realignment funds, and can be Medi-Cal reimbursable.

URGENT CARE

Urgent care programs can be seen as a hybrid of crisis intervention programs, crisis stabilization centers and drop-in/walk-in support programs where individuals can be assessed for their needs and crisis stabilization provided on site. The urgent care services include medication evaluation and management, crisis intervention, brief intervention/stay, psychiatric evaluation and social services with information and referrals.

These programs are run by a multidisciplinary team of physicians, nurse practitioners, Masters level clinicians and mental health specialists. Crisis counseling occurs in these settings as well as

psychiatric evaluations for individuals on 5150 holds. Los Angeles County Mental Health has utilized these programs extensively and has found them to be cost-effective, efficient, and to reduce the need for 5150 hospitalizations dramatically. These programs can be funded by Mental Health Services Act funds, AB109 dollars, county general funds, Medi-Cal funds, Realignment funds and SB82, Mental Health Wellness funds.

CRISIS RESIDENTIAL SERVICES

Crisis residential services are a 24 hour care community based on alternative inpatient hospitalizations for adults experiencing an acute psychiatric episode. While these programs have psychiatric coverage, they are often more social in nature and do not have the medical orientation of a hospital stay. These programs have proven to be effective in avoiding hospitalizations and are considerably less expensive than hospital costs. Participation in these programs is voluntary and they cannot accept 5150 referrals. Sacramento County has a crisis residential program through a contract with Turning Point and is available by referral from the county mental health system.

"SOFT" SERVICES

Good crisis intervention programs have a number of ancillary programs that offer support during times of crisis. These programs may include such things as hotlines or warm lines. Suicide Prevention hot lines are good examples of this type of program. Soft services may also include patient support groups, wellness or drop-in centers that allow individuals in crisis to talk to someone who is not a licensed professional rather than needing to go to an emergency room or a crisis stabilization center. There is a long history of the utilization and effectiveness of these programs which can be funded by MHSA funds, realignment funds and often are run by volunteers and community-based organizations.

APPENDIX C

SUPPORTING INFORMATION

- *Lessons Learned from California's AB 2034 Program*: California Institute of Mental Health
- *Mental Health Services Act (Prop 63): Best Practices*: California Institute of Behavioral Health Solutions
- *Alameda Model: An Effort Worth Emulating*: Western Journal of Emergency Medicine.
- *Independent Expert Review Final Report*: Callahan and Associates
- Medicaid IMD waiver (Matsui)
- Best Practices-Crisis Response and Diversion: Maryland Health Care Commission Urgent Care Los Angeles (Exodus Recovery)
- Sacramento County Mental Health Advisory Board minutes
- Sacramento County Assembly Bill 109 Realignment reports