CONTRA COSTA
HEALTH SERVICES

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CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

The Contra Costa County Mental Health Commission has a dual mission: 1) To influence the County's Mental Health System to ensure the delivery of quality services which are effective, efficient, culturally relevant and responsive to the needs and desires of the clients it serves with dignity and respect; and 2) to be the advocate with the Board of Supervisors, the Mental Health Division, and the community on behalf of all Contra Costa County residents who are in need of mental health services.

CONTRA COSTA COUNTY MENTAL HEALTH COMMISSION

Special Meeting □ September 3, 2009 □ 4:30-7:30 p.m.

651 Pine Street, Martinez 94553

The Commission will provide reasonable accommodations for persons with disabilities planning to participate in Commission meetings who contact the Executive Assistant at least 48 hrs. prior to the meeting at 925-372-4439.

AGENDA

1. 4:30 **CALL TO ORDER / INTRODUCTIONS**

2. 4:45 **PUBLIC COMMENT.** ***[First 5 Submitted]***

The public may comment on any item of public interest within the jurisdiction of the Mental Health Commission. In the interest of time and equal opportunity, speakers are requested to observe a 3-minute maximum time limit (subject to change at the discretion of the Chair). In accordance with the Brown Act, if a member of the public addresses an item not on the posted agenda, no response, discussion, or action on the item may occur. Time will be provided for Public Comment on items on the posted Agenda as they occur during the meeting. Public Comment Cards are available on the table at the back of the room. Please turn them in to the MHC Vice Chair.

3. 5:15 **PROPOSED PSYCHIATRIC FACILITY**

A. Contra Costa Health Services: Alternatives and Current Plan

B. Mental Health Commissioners' Input: Alternatives and Issues

C. Possible Modifications

D. **PUBLIC COMMENT.**

The public may comment on this item on the agenda. In the interest of time and equal opportunity, speakers are requested to observe **a 3-minute maximum time limit** (subject to change at the discretion of the Chair). In accordance with the Brown Act, if a member of the public addresses an item other than the one related to this agenda item. no response, discussion, or action on the item may occur. Public Comment Cards are available on the table at the back of the room. Please turn them in to the MHC Vice Chair.

E. Next Steps

Action 1. Commission Recommendations

Action 2. Decision on September 30 public forum

3. Confirmation of September 10 Commission meeting

4. 7:15 **ADJOURN MEETING**

The next regularly-scheduled meeting of the Mental Health Commission will take place September 10, 2009.

Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the staff to a majority of the members of the Mental Health Commission less than 72 hours prior to that meeting are available for public inspection at 1340 Arnold Drive, Ste. 200, Martinez during normal business hours.

The Contra Costa County Mental Health Commission is appointed by the Board of Supervisors to advise them on all matters related to the county's mental health system, in accordance with mandates set forth in the California State Welfare & Institutions Code, Sections 5604 (a)(1)-5605.5. Any comments ore recommendations made by the Mental Health Commission or its individual members do not represent the official position of the county or any of its officers.

CONTRA COSTA HEALTH SERVICES – MENTAL HEALTH

A Review of the Literature and Existing Programs With Similar Elements to Proposed Psychiatric Campus in Contra Costa County August 24, 2009

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In order to address the question of "What is the precedent?" for the proposed psychiatric campus in Contra Costa County, a few findings from a brief literature and internet search for research and comparable existing programs are presented here. While not all elements of care proposed for the new Psychiatric Campus in Contra Costa County are found in one place, our research allows us to highlight a few evaluations and specific programs that address aspects of our proposed service and the need for closely coordinated levels within an acute care system.

I. The Literature

SUMMARY

- ✓ *Residential crisis program provides near-equivalent effectiveness for significantly less cost.*
- ✓ *Treatment of an acute episode in a community residential alternative was as effective as treatment in a hospital psychiatric ward.*
- ✓ *What drives the appropriate functioning of the continuum is coordination and smooth, efficient movement along the levels of care.*
- ✓ *In New York State, each Comprehensive Psychiatric Emergency Program must include: Emergency services, extended observation beds, crisis outreach, and crisis residential care.*

A. Residential Crisis Care as an Alternative to Hospitalization

Cost Effectiveness

Recognition of the need for alternatives to hospitalization for acute psychiatric care is not new. Alternatives became more common in the 1980s and 1990 with the rise of managed care for cost containment purposes.[1]

A study of the cost effectiveness of hospital vs. residential crisis care for serious mental illness was conducted by the National Institute of Mental Health in 2002.[2] This study concluded that "Residential crisis programs may be a cost effective approach to providing acute care to patients who have serious mental illness and who are willing to accept voluntary treatment. Where resources are scarce, access to needed acute care might be extended using a mix of hospital, community-based residential crisis, and community support services." This study found that the cost for an acute care episode treated in a residential crisis setting was 44% lower than in a hospital. "The residential crisis program provides near-equivalent effectiveness for significantly less cost."

Treatment Outcome

While the earlier cost study (above) found "near-equivalent" effectiveness in outcomes, a 1998 study, in which clients were assigned to an inpatient hospital setting or to a community residential alternative and followed for six months, concludes that "In voluntary patients with severe, persistent mental illness, treatment of an acute episode in a community residential alternative was as effective as treatment in a hospital psychiatric ward.[3] In further discussion, they report that length of stay was longer for patients in the residential alternative than for patients in the hospital (19 v. 12 days), that
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symptom severity decreased in both groups equally, and that overall patient satisfaction did not differ. (Although patients in the community residential alternative were more satisfied with the food!)

B. The Expanding Continuum of Care

What Makes the Continuum Work

An analysis of the effectiveness of the expanding continuum of mental health care stresses that what drives the appropriate functioning of the continuum is coordination and smooth, efficient movement along the levels of care. Services are "delivered at the right point in the continuum of care – that point at which the greatest value is added."[4]

In this article, Lefkovitz stresses that many organizations offer multiple levels of care but integration among them is lacking. Each program functions fairly autonomously – adding to fragmentation, confusion and inefficiency. Centralized planning and communication structures are important. "In order for the whole to be greater than the sum of its parts, ongoing communication and problem solving should take place within the context of a shared, broader vision."

The New York Crisis Continuum

In response to massive overcrowding in emergency rooms and inpatient programs, the State of New York developed its Comprehensive Psychiatric Emergency Program (CPEP). Between 1990 and 1994, thirteen sites were certified to operate CPEPs. Today there are 15 sites. Each CPEP must include: Emergency services, extended observation beds, crisis outreach, and crisis residential care. The intent of this is to provide an integrated continuum of emergency care as a support to, not substitute for, other community service providers. [5] An example of this is provided in the next section of this report.

II. Multi-Level Acute Care Programs -- Examples

Westchester, New York -- Comprehensive Psychiatric Emergency Program

One example of the New York model is the Behavioral Health Center at Westchester Medical Center. Available 24 hours a day, 365 days a year, their CPEP services include:

- ✓ The only freestanding Psychiatric Emergency Service between New York City and Albany
- ✓ Mobile Crisis Intervention Services
- ✓ Extended Observation Beds (72 hours) as an alternative to longer-term hospitalization
- ✓ A Crisis Residential Program that allows for brief stays and treatment in community locations as an alternative to hospitalization

Westchester's Center is on the grounds of the Westchester Medical Center – providing easy access to medical care as well.[6]

Vermont -- Mental Health Futures Plan

As it began planning to replace its outdated psychiatric hospital, Vermont developed a broader plan to transform their system with a Comprehensive Continuum of Care for Adults with Mental Illness.[7] In addition to rebuilding its inpatient hospital program and enhancing its community infrastructure, the 2006 Vermont Plan will transform the Acute Care System with the following components:

- ✓ A Recovery residential program

- ✓ Secure Residential Treatment Capacity
- ✓ Crisis Stabilization Beds
- ✓ A Care Management System

Seattle, Washington - Transitional Resources
Transitional Resources is an independent non-profit in the Seattle area. They offer a continuum of services for mentally ill adults. At the acute end of that continuum, they offer two diversion beds that provide intensive, short-term, 24 hour supervision and support for adults in psychiatric crisis. The program is designed to rapidly stabilize the crisis and return the consumer to his or her own home, usually within 3-5 days. TR also provides an Intensive Congregate Care rehabilitative and residential program for those with the most serious ands persistent mental illnesses, who might otherwise be at high risk for institutionalization, homelessness or incarceration.[8]

Phoenix, Arizona --Psychiatric Recovery Center West. Although the Center serves as Title 36 screening agency for emergency involuntary hospitalization in Maricopa County, the goal of Psychiatric Recovery Center West (PRCW) is to divert people from inpatient hospitalization and communicate the message of hope and the possibility of recovery. Since the implementation of a recovery mission, hospitalizations have decreased to the current rate of 4%. *(Note: Susan Medlin, CCMH Office For Consumer Empowerment Coordinator, plans to visit the site and tour the facility during the week of 8/24-28, 2009, and bring back a report).*

Towson, Maryland --Mosaic's Residential Crisis
Mosaic offers a broad continuum of community-based services to individuals experiencing psychiatric difficulties. Included in this broad continuum of services, they have a program that provides intensive services to individuals experiencing increased psychiatric symptoms where an alternative to or prevention of hospitalization is needed.[9] The crisis facilities are houses that provide 24/7/365 staffing and psychiatric rehabilitation and treatment to these individuals who are in psychiatric crisis or at imminent risk of psychiatric crisis. All of Mosaic's therapeutic crisis beds are licensed by the Department of Health and Mental Hygiene as prevention to and/or alternative to hospitalization. They state on their website that payment for these crisis services is significantly less expensive than acute inpatient hospitalization, lengthy emergency room stays, and/or hospitalization.

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[1] Robert K. Schreter, Md. *Psychiatric Clinics of North America*, Volume 23, Issue 2, 1 June 2000, Pages 335-346 as accessed via ScieneDirect.com.
[2] Fenton WS, Hoch JS, Herrell JM, Mosher L, Dixon L., "Cost and cost effectiveness of hospital vs residential crisis care for patients who have serious mental illness," *Archives of General Psychiatry*, April, 2002, 59(4):357-64.
[3] Fenton WS, Mosher LR, Herrell JM, et al. "Randomized trial of general hospital and residential alternative care for patients with severe and persistent mental illness." *Am J P sychiatry, 1998 Apr; 115:516-22.*
[4] Paul M. Lefkovitz, PhD, "The continuum of care in a general hospital setting," *General Hospital Psychiatry*, July, 1995, Volume 17, Issue 4, 260-267.
[5] John M. Oldham, Mary E. Demasi, "An integrated approach to emergency psychiatric care," *New Directions for Mental Health Services*, Volume 1995, Issue 67, pp 33-42.
[6] http://www.worldclassmedicine.com/homepage_behavioral.cfm?id=16
[7] **http://healthvermont.gov/mh/futures/documents/Futures_Plan.pdf**
[8] www.transitionalresources.org/programs.php
[9] http://carroll.md.networkofcare.org/veterans/resource/agencydetail.cfm?pid=MosaicCommunityServiceResidentialCrisisprogram_748_17_0

CONTRA COSTA HEALTH SERVICES

CHART OF CAPITAL FACILITIES ALTERNATIVES

Draft – 8/20/09

FUNCTION	OPTIONS	PROS	CONS	PROPOSED
Inpatient Psychiatric Care	No Inpatient Psychiatric Care in County	•	• No access to acute beds within county for any mental health consumer; • Costly to contract these services outside of the county • Locked facility • May not use MHSA Capital Funds • Inconvenient for family and/or friends – must travel out-of-county	
	Inpatient Psychiatric Care in County, with 10 Beds Remaining	• Access to acute beds within the county; • Convenient to family and/or friends within the county; • Loss of 10 acute beds in County • Operates under title 22	• Traditional medical-model hospital based psychiatric unit • Locked facility • May not use MHSA Capital Funds • Reduces existing beds from 20 down to 10 • May have to contract for acute beds out-of-county • Must contract for acute beds for children to out-of-county • Transportation to Martinez may be difficult for family and/or friends • Most restrictive level of care for MH consumer • Operates under Title 22 regulations	

FUNCTION	OPTIONS	PROS	CONS	PROPOSED
			• No BART Access	
	Inpatient Psychiatric Care in County, Retain Current 20 Beds	• Access to acute beds within the county; • No loss of acute inpatient hospitalization beds in county • Convenient to family and/or friends within the county; • Operates under Title 22 regulations	• Traditional medical-model hospital based psychiatric unit • Locked facility • Most restrictive level of care for MH consumer • May not use MHSA Capital funds • Must contract for acute beds for children out-of-county • Transportation to Martinez may be difficult for family and/or friends • Operates under Title 22 regulations • No BART Access	**Continue to Operate current Inpatient Psychiatric Unit at existing (20) Bed capacity to provide access to acute beds for Contra Costa County mental health clients**
	Expand acute beds in inpatient/acute facility	• Provides access to more acute beds within County; • Convenient to family and/or friends within the county; • Operates under Title 22 Regulations	• Traditional medical-model hospital based psychiatric unit • Locked facility • Most restrictive level of care for MH consumer • May not use MHSA Capital funds • Transportation to Martinez may be difficult for family and/or friends • Operates under Title 22 regulations	**Construct new Psychiatric Health Facility (PHF) on campus adjacent CCRMC – include as part of the Continuum of Care model, offering acute beds in a non-medical-model tradition**
Psychiatric Health Facility	Increase acute beds which are operated under less-restrictive Statutes	• Not part of the traditional medical-model based care • Increases bed capacity within the county for mental health consumers • More cost-effective, flexible	• May not use MHSA Capital Funds to construct • Locked-restrictive setting	**Construct 16-bed Psychiatric Health Facility on Continuum of Care Campus as part of a Mental Health Recovery Services Program.**

FUNCTION	OPTIONS	PROS	CONS	PROPOSED
		operation (than inpatient alternative) • Operates under Title 9 Regulations		
Institutional Settings (i.e., IMD's)	Contract these services out	• Provides alternative placement for those clients who qualify • Alternative to inpatient hospitalization	• Locked facility • Long-term residential care • May not use MHSA Capital Funds • May not be located within the County • Transportation to facilities for family and/or friends may be a problem	
Crisis Residential Facility (CRF)	Currently: One in Concord (Niereka House) – 12 bds	• Provides in-county service for mental health clients • Provides community-based treatment alternative to hospitalization, or may prevent re-hospitalization • Unlocked and less restrictive level of care • May contribute to less involuntary treatment • Family and/or other support to the client don't have to travel out-of-county	• Not enough Crisis Residential Facility beds to accommodate need within the county; • Some MH Clients have to go outside of County for Crisis Residential care • Costly to contract and/or place clients out-of-county • Transportation to facilities for family and/or friends may be a problem •	
	One CRF in County, Centralized, adjacent CCRMC	• Provision of voluntary, lower-security, longer-term treatment within the county. • Adds a community-based treatment Alternative to hospitalization, or may prevent re-hospitalization • May be constructed using	• May be difficult for clients from other two regions to get to the centralized site • No access to services for children • Transportation for family and/or friends may be difficult	**<u>Construct 16-bed Crisis Residential Facility (and support facility for administration, dietary, storage, receiving, medical records) as part of a new Mental Health Recovery Services</u>**

FUNCTION	OPTIONS	PROS	CONS	PROPOSED
		MHSA Capital Facility Funds • Unlocked and less restrictive level of care • Short transfer to CCRMC for client if medical services are needed • May contribute to less involuntary treatment • Adding a CRF in CCC increases capacity for services and access to services for TAY, Adults, and Older Adults within the county • Centralizing the function creates the economies of scale (less costly to spread the beds out across the regions). • Operates under Title 9 (more flexible and supportive of wellness & recovery approaches) • Bus service is available to the centralized campus		**Program to include a continuum of care to address needs of clients from a wellness and recovery perspective.**
	Two CRF's in County	• Adds a community based treatment Alternative to hospitalization, or May prevent re-hospitalization • May be constructed using MHSA Capital Facility Funds • Unlocked and less restrictive level of care • Provides easier access for	• May be difficult for the clients from the one region without a CRF to get to one of the two sites. • Transportation for family and/or friends may be a problem if sites aren't close to BART or Bus service • Dilutes amount of funding	

FUNCTION	OPTIONS	PROS	CONS	PROPOSED
		clients in two of the three regions of Contra Costa County • increases capacity for services and access to services for TAY, Adults, and Older Adults within the county • May contribute to less involuntary treatment • Operates under Title 9 (more flexible and supportive of wellness & recovery approaches)	available from Capital Facility Funds • No access to services for children • May be more costly to duplicate the service in more than one region • Factor in cost of transferring client for medical care if needed.	
	Three CRF's in County	• Adds a community based treatment Alternative to hospitalization or May prevent re-hospitalization • May be constructed using MHSA Capital Facility Funds • Unlocked and less restrictive level of care • Easy access for all clients within their respective region • Operates under Title 9 (more flexible and supportive of wellness & recovery approaches) • May contribute to less involuntary treatment	• May not be cost effective to duplicate the services across three regions. • No access to services for children • Dilutes amount of funding available from MHSA Capital Facility Funds. • Factor in cost of transferring client for medical care if needed.	
Crisis	Psychiatric	• May result in more cost	• Results in very long waits for	

FUNCTION	OPTIONS	PROS	CONS	PROPOSED
Stabilization (5150 Receiving Center)	component of CCRMC's Emergency Department	efficient delivery of service	MH clients • Clients may decompensate quickly while awaiting triage, resulting in higher level placement • Once triaged to CSU from ED, locked site	
	Not a Psychiatric component of the ED, but within same building, with Separate entrance	• Provides quicker/easier access for clients • Medical emergencies can quickly be routed to ED	• Psychiatric Emergency Service is a locked site; • Remodeling costs due to changes in facility; •	
	Re-locate to a Assessment and Recovery Center (Urgent 24/7 MH Care/Outpatient Care) to separate continuum of care campus	• Provides quicker/easier access for clients • Allows for movement of client up and down continuous levels of care • Will be an un-locked site • May be constructed using MHSA Capital Facility Funds		**Re-locate CSU to a new Mental Health Recovery Services Program Campus as part of a new continuum of care approach. Urgent and outpatient mental health care services to be provided 24/7**
Urgent 24/7 Mental Health Care/Outpatient *(Assessment & Recovery Center)*	Include on a continuum of care campus	• Drop in services on an outpatient basis 24/7 • Separate entrances for voluntary and involuntary care • Opportunity for early intervention, or prevention of an acute psychiatric episode, thereby avoiding acute hospitalization • Unlocked facility • May be constructed using		**Construct an Assessment and Recovery Center to meet the needs of mental health clients needing urgent and outpatient mental health care 24/7 – to include voluntary and involuntary access separately. To be part of a continuum of care campus.**

FUNCTION	OPTIONS	PROS	CONS	PROPOSED
		MHSA Capital Facility Funds. • Access to services for Children, TAY, Adults and Older Adults		
THE FOLLOWING REPRESENT VARIOUS HOUSING OPTIONS AVAILABLE TO CLIENTS:				
Board and Care	•	• Part of a range of housing types which suit the different needs of consumers • Good setting for clients needing caretaker services • May use MHSA Housing funds to provide additional augmented services	• May not use MHSA Capital Funds • Not enough B/C in certain regions of county • May have environmental, programmatic and/or staff deficiencies • No incentive to prepare and/or encourage residents to move on to independent living situations	**Utilize CSS Funds for FSP's to Augment**
Supported Independent Living	• Rental housing • Individual Units in a rental housing project (i.e., apartment building) •	• Part of a range of housing types which suit the different needs of consumers • Allows for unification of the family unit • Moves client along the recovery continuum • Provides rental subsidies and supportive services to clients, and targeted to serve persons with mental disabilities	• May not use MHSA Capital Funds • Different diagnoses require different models of housing • MHSA Housing funds are available through CalHFA	**Utilize CSS funds for FSP's** **Utilize MHSA Housing Dollars through Cal-HFA funds assigned**
Single Room Occupancy	• Multiple bedrooms in a house	• Part of a range of housing types which suit the different needs of consumers	• May not use MHSA Capital Funds • Different diagnoses require different models of housing • Needed support services may not be available	**Utilize CSS funds for FSP's**
Transitional	•	• Part of a range of housing	• May not use MHSA Capital	**Utilize CSS funds for FSP's**

FUNCTION	OPTIONS	PROS	CONS	PROPOSED
Housing and Residential Treatment		types which suit the different needs of consumers • Necessary parts of the housing continuum • Divert clients from inpatient hospitalization • Provide brief respite from situational stresses	Funds • Different diagnoses require different models of housing • Stays are time-limited	**<u>Utilize MHSA Housing Dollars through Cal-HFA funds assigned</u>**
Emergency Housing (Shelter)	•	• Part of a range of housing types which suit the different needs of consumers • Provides temporary housing option	• May not use MHSA Capital Funds • Different diagnoses require different models of housing • No permanent housing may be available • Limited mental health services are offered in homeless shelters	**<u>Utilize CSS funds for FSP's</u>**
Public Housing	•	• Part of a range of housing types which suit the different needs of consumers • Allows for unification of family unit	• May not use MHSA Capital Funds • Different diagnoses require different models of housing	**<u>Utilize CSS funds for FSP's</u>**
Shared Housing	•	• Part of a range of housing types which suit the different needs of consumers • MHSA Capital Facilities Funds may be used for this type of housing •	• May not use MHSA Capital Funds • MHSA Housing Funds available through CalHFA • Many clients don't want to "co-habitate" • Different diagnoses require different models of housing	**<u>Utilize MHSA Housing Dollars through Cal-HFA funding</u>**