

# Review of San Benito Behavioral Health Services 2018



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Health and Human Services Consulting  
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### Executive Summary

Health and Human Services Consulting was hired to conduct a review of the San Benito County Mental Health System. These recommendations were to include the following:

- Methods to reduce or eliminate “serial 5150” holds
- Suggest ways to ensure timely mental health care at the level of care needed in the least restrictive setting
- Ensure strategies to exclude unnecessary or excessive seclusions
- Expand services to reduce the need for hospitalizations
- Ensure children and youth services to ameliorate conditions that might lead to higher levels of care
- Increase outreach to Medi-Cal beneficiaries, specifically the Latino/Hispanic Community
- Suggest policies, procedures and practices to provide treatment in the most integrating setting
- Outline training and development for both San Benito Behavioral Health and Hazel Hawkins Hospital as it pertains to the care of shared clients

The process of the review included interviews with SBCBH line staff without supervisors or managers present. These involved adult and children clinicians, case managers and medical staff. The administrators, supervisors and fiscal staff were questioned as well. There were interviews with clients at the clinic, in their homes and by telephone. The emergency room nurses and medical director were seen at Hazel Hawkins Hospital. The Hollister Police, both administrative and line officers were interviewed. A local service provider gave a presentation and others were interviewed by telephone. Written documents that were programmatic, procedural and fiscal were reviewed over the course of this process.

During my review eight deficiencies emerged that mandate improvement:

- The means and method of inpatient hospitalization assessment
- There are few therapeutic resources between counseling and hospitalization
- Limited to no therapeutic engagement for individuals waiting bed space
- Scarce mental health resources for jail inmates
- Poor medical communication for patients shared with Hazel Hawkins Hospital
- Unclear assessment path for children with no evening hours for families
- Need for a philosophy, resources and crisis planning to keep children at home
- Mixed caseloads mitigate the potential impact of Full Service Partnerships
- These deficiencies all contribute to serial “5150” holds

Seven areas of tension that impact the effectiveness of mental health services

- Psychotherapist are not often the most suited for crisis assessment and resolution
- Policy of interviewing 5150 patients once every 24 hours exasperates the strained partnership with Hazel Hawkins and puts clients at risk
- Lack of case review for shared patients gives no opportunity for improvement
- Limited nonprofit partners leaves the County few options for special needs
- Lack of a County funded Forensic Mental Health strains existing psychiatric resources
- Scare time for planning with parents leaves them isolated and powerless

### Observations, Analysis and Recommendations

#### Outreach and brokering services

Case Management staff provide traditional mental health services from coordination of services to client assessment and monitoring of client progress. Staff report a significant increase in case managers, which has resulted in more responsive services. They have caseloads of primarily youth or adults in addition to Full Service Partnership (FSP). Caseloads include clients who have a more moderate need for case management. The utility of this case load system for a small county is obvious but the overall effectiveness for high need clients is questionable. It is a creative use of resources to have case managers carry a mixed case load of intensive and moderate need clients. My experience is that it would be beneficial to both client groups, if case managers were able to practice their craft with a specific client group with similar needs.

A typical case load for adults includes 4 of these being clients in need of intense services as defined by the MHSA Full Service Partnership (FSP). While this practice appears more equitable it does not give the staff time needed to focus on the immediate need and chaos often generated by the most vulnerable client group. This model does not give staff the time to focus on the needs of clients as they show early signs of distress. If a small number of staff managed a lower case load of high need FSP clients, they might be more available for early intervention and avoid the need for involuntary treatment.

I recommend a group of FSP case managers whose focus would be on this exclusive group of clients with a history of repeated hospitalizations. This would require a smaller case load of 8-10 clients. This type of availability would permit the staff member to cut through red tape and quickly assist clients in a crisis state with a variety of diversion resources. This improvement could be added with the counties plan to add addition case management staff. At the same time the county needs to add clear criteria that defines when clients exit FSP, so slots are available to add clients who require this level of care.

The additional time to intervene early could likely avoid costly and demoralizing hospitalization. A 'Whatever It Takes' approach means to find the methods and means to engage an individual, determine their needs, and create collaborative services and support to meet those needs. Case managers with a smaller case load of high need clients would then have time for the following:

- Daily Maintenance Plan
- Identifying Triggers and an Action Plan based on clients healthcare directives
- Identifying Early Warning Signs and an Action Plan
- Identifying When Things Are Breaking Down and an Action Plan
- Crisis Planning

In terms of resources, the adult and youth teams need a consistent access to a social model residential alternatives to hospitalization. At present there doesn't appear to be a mid-range resource between outpatient counseling and involuntary hospitalization. I suggest the SBCBH add social model Crisis Residential. This contracted service would permit a higher level of care, without the stress and cost generated by a search for a locked setting, while clients wait their fate in a locked room at the local emergency room. Crisis Residential would give clients another resource for those who need time away from their current environment. As a hospital alternative, these social model facilities can also work through suicidal risks without an involuntary hold. These resources are available in the region, cost less and could be more available than the shortages of beds found with psychiatric hospitals. A similar hospital diversion resource for youth is available that focuses on acute psychiatric crisis and can offer a step down and stabilization from a locked setting. Unfortunately, it does not accept Medi-Cal but MHSAs funds could support this as a limited but valuable resource. I would recommend two beds for adults and one for youth. Given the low volume of youth it is reasonable to start this process on a "Fee for Service" basis until the approach validates that it is economically feasible for the number of youth served. It will take some time for staff to properly use this new resource but its value will be apparent with time. Remember these beds can be a valuable step-down after an acute hospitalization

Another tool to consider that would assist clients to regain their composure in a crisis is sometimes referred to as a "warm room". People who are feeling overwhelmed often benefit from a simple, safe, calm environment supported by peers as staff. When they are forced to travel in hand cuffs in a police cruiser to a chaotic hospital emergency room, one can imagine that this does little to lower their crisis threshold. The Crisis Residential Provider suggested earlier in this report could also offer a day setting that would be conducive to a "Warm Room" concept. Since the program would already process the staffing, a client could be added to their day rooms where they might recover their equilibrium enough to be returned to their original living situation. This of course would be followed with a plan for regular follow up both in person and by phone.

It would also be a safe setting to offer time to assess, what resources could be offered to avoid a further escalation resulting in an involuntary placement. It would certainly be a more healing atmosphere than Room 1 at Hazel Hawkins Memorial.

How might we transport clients to residential treatment or the warm room in a manner that does not escalate the anxiety clients are already experiencing? I would recommend that this assessment be completed at their place of residence or in a clinical setting. The staff could then transport clients and avoid a police response or an expensive ambulance. Either of these transportation methods gives a message that the person is either a criminal or is in a health emergency. This is not the wellness message we are hoping to give our clients and their families.

### Clinical Team and Crisis Response

Even with a small team of professional counseling staff, San Benito has done an excellent job of recruiting interns. One of the best ways to attract hard to find mental health professionals in small counties is to grow your own. The stipend mileage reimbursement are very effective incentives. The small full-time clinical team carries a very large case load for outpatient providers. In addition to providing psychotherapy this unit answers crisis calls for 5150 evaluations. Frankly, using psychotherapist to provide crisis intervention and 5150 assessments might not fit with the culture of psychotherapy, which usually encourages a good deal of history taking and relationship building to be effective. Honing a specific team of professionals whose role is to intervene in a mental health crisis, deescalate the situation and design a community based plan to avoid a hospitalization can be quite effective. Regular crisis intervention training would be helpful as well as a case review to improve outcomes should be available to this group.

I would also recommend the 5150 assessments being assigned to the case management unit. These individuals know the clients. They are already tracking who is approaching a life crisis and are comfortable operating in the field. I reviewed a formalized training for the important 5150 assessment. The staff reported that this training was not provided, at least recently. Any mental health provider designated by the BHS Director should receive an annual training on the 5150 process that should include a philosophy of diversion and a knowledge of resources. This should include the triangle of professionals who are the corner stone of this process, Mental Health, Law Enforcement and Hazel Hawkins. It is understood that this training will only reach fruition if both the Hospital and law enforcement comprehend the value of this approach. I suggest the new MOU with Hazel Hawken's include the 5150, patients' rights training and be outlined in the MOU and approved by Hospital administration. Law Enforcement seemed opened to

further mental health training. The law enforcement time devoted to this effort could be justified if it were part of the Peace Officers Standards and Training (POST) requirements. A discussion with the Hollister Police and Sheriff could outline the path for these trainings to be part of required POST trainings

Further, I recommend that a “hospital liaison” be established to keep track of existing psychiatric inpatient and social model resources. This important role can be administrative, saving limited clinical resources. In my experience, the relationships created by this function can be very effective in obtaining these illusive resources.

A quick improvement could be accomplished with the purchase and maintenance of a high speed reliable fax machine. Finding a hospital bed in the Bay Area takes multiple phone calls and advocacy for the client and referring county. Gaining admission often depends on how fast you can send the required client admission packet to the receiving hospital. The current process is hampered unnecessarily by a faulty fax machine. This simple improvement could be a quick win.

I question the need to have law enforcement as the lone source for transporting the individual in need of a 5150 assessment to the Emergency Room. Cuffing an already upset individual and placing them in a police cruiser only heightens the person’s emotional state. Multiple clients reported the trauma they experienced from this process. Case Managers, who are comfortable with field work could evaluate the person at their residence. In my opinion, these type of on-site assessments provide the evaluator with a real life survey of the client’s resources and state of wellbeing. Police could accompany the case manager if warranted instead of the officer going it alone. Being on the scene a trained professional can often lower client’s anxiety. The option of keeping the client in their residence is increased, if we evaluate them at home. This permits a follow up plan that can result in a positive outcome. Once you are in police custody and taken to the ER a momentum is established that most often results in an inpatient stay. Of course the staffing to achieve this **mental health first** assessment approach must be balanced with the resources available to a small county. Perhaps a day time effort could initiate this approach and be evaluated for effectiveness in reducing trips to the ER. If successful this could be expanded as a PM shift effort with the remaining hours falling to law enforcement emergency personnel. As SBCBH expands community and in-home assessments, I recommend you begin with willing staff, rewrite the procedures, provide training and a feedback loop with staff so you can evolve this procedure informed by actual practice. Finally the County might consider more use of its

on cage car. Clients would be more comfortable being escorted to a placement by the staff they know, than a medical or police transfer.

### Housing

The current scattered site housing in apartments works well. The county should be congratulated for establishing this essential resource. Under the theme that housing is health care. Most mental health professionals understand that these impoverished individuals cannot really improve their mental health without adequate, safe and affordable housing. There is always a need for stable housing that clients can return to after a difficult episode. I recommend that the County continue to plan, advocate and seek special needs housing. This planning process must constantly be in play so that the county is poised to take advantage of the next housing opportunity for no-income clients.

### Mental Health Medical Team and Hazel Hawkins Memorial

San Benito is fortunate to have the wealth of psychiatry and nursing staff not often scene in small counties. Their use of tele-psychiatry both at the main clinic and the Esperanza Center significantly increases access for clients. This service could be improved by increasing nursing time so they are always part of the tele-psychiatry model. RN's have the ability to complete medication consents and verbal orders, while case managers do not. This change would streamline the process for the medical team and clients alike. Another quick win could be accomplished by expanding the resources to repair or replace the glitchy Tele-Psychiatry connection. The physician is regularly cut off in the middle of a client session. I was able to witness this on a visit with the team, where Dr. Fruchter was cut off during our interview. The need to write paper scripts and call the pharmacy reduces the time available to treat clients. Adding a module in the electronic medical record to e-prescribe could speed this cumbersome paper process and be advantageous for quality assurance in the complicated area of psychotropic medications. My understanding is that the County is about to adopt a new electronic health record (EHR). This would be an ideal time to add e-prescribing module.

The recent addition of drop-in hours for clients in crisis has resulted in improved outcomes for people in crisis. Recruitment of nursing and retention of nursing staff could be helped significantly by completing a salary survey to come more in line with the regions pay scales. They are about to lose a long time RN who is volunteering as many



hours as she is on the payroll. A cursory review leads one to believe that this volunteer time will need to be replaced to stay even with the current level of staff. While not requiring “psychiatric nurses” saves money and enhances recruitment, new staff should be given sufficient time to learn the psychiatric side of medical care.

The emergency room facilities at Hazel Hawkins Hospital are quite impressive for a small community. The medical staff were surprisingly accepting in their role with the 5150 process and appeared to sympathetic to the challenges of treating patients with a severe mental illness in a small county. The Medical Director, Dr. Bogie believes that the hospital and San Benito Mental Health are making positive strides in the relationship. Nursing staff who have worked in surrounding counties reported a better experience with the San Benito mental health professionals than in other counties. However, the clients interviewed consistently reported that they were treated rudely, talked down to and routinely not given access to reasonable requests. While the County is not responsible for the Hospital employees, a regular training outlining client rights and mental health symptoms would be advantageous to create an improved client experience in Hazel Hawkins Hospital. As the contracted ER staff is constantly changing the work of orienting this staff to mental health procedures, resources and basic client rights is a never ending process. As mentioned earlier, this ongoing training and orientation should be memorialized in the new Hazel Hawkins-County Behavioral Health updated MOU.

ER staff reported that county mental health staff only visit or reassess a client they have left in the ER once every 24 hours. This common practice should be changed and turned into a procedure that outlines an assessment of the client at the change of shifts. I would also recommend an established follow up visit by the case manager or 5150 assessor to determine if a discharge to a lower level of care is warranted. The ER staff would feel more a part of the mental health effort if county staff shared the responsibility of caring for their clients while they were awaiting placement. Mental health staff who are trained in crisis intervention would be a welcome addition by the clients and hospital staff, as well. When the SBCBH staff reassess the clients at the Hospital, this should include crisis intervention treatment consistent with the client’s ability to make use of this effective counseling technique. This recommendation implies that the assigned staff are trained and supervised for this type of intervention. If local mental health could establish a consistent staff person or two for regular follow up and training with HHH staff it would help establish coordinated care approach.

It was not clear to me how case coordination is handled for clients with both mental health and substance abuse issues. The Hospital has recently added a substance use navigator and has a positive connection with Bright Heart on-line services to follow opioid addicted clients started on Buprenorphine. The County has an outpatient substance use service but no residential or social model detox. Substance use services were not part of this review but the clear connections between substance use and mental health problems calls for close coordination and expansion of services.

There is a chasm in care coordination between the county mental health medical team and hospital staff. Medical staff on both sides of this equation claim to have little to no communication with the other side. Both mental health clinic staff and hospital staff professed a desire to share medical information concerning the patients they share but little has been done to close this communication gap. A simple solution seems to be adding a link to the Anasazi Clinical Record at the ER. While the staff do in fact access this client information, hospital staff claim to have no information except what is provided from the 5150 assessment. The opportunity to share medical information for needed care coordination is readily available and requires no release. Yet, this opportunity is regularly missed for patients with complex care needs. In addition, I recommend a monthly meeting to review common cases both those with successful outcomes and those who had problems. A Grand Rounds type of approach is familiar to hospital staff and should be installed as reoccurring process. This time could also be used to orchestrate needed follow up and make prevention efforts for frequent customers. I would also encourage HHH to either contract for a psychiatric consult or place the San Benito County Psychiatrist on staff. Finally, the need to rework the very dated 1999 MOU between HHH and SBCBH seems obvious.

The partnership with primary care at the FQHC, San Benito Health Foundation is promising. Both at the hospital and mental health clinic the coordination with primary care for this vulnerable population should be improved. This group of high risk clients dies 25 years ahead of the general population from chronic illness. The clients I interviewed listed the lack of primary care as one of their most significant difficulties. The more we can integrate health care for this group of people the healthier they become. It requires an approach to encourage complex care, so that everyone served by mental health is attached to a primary care clinic. Case management staff as part of their annual assessment should insure that all clients are assigned to a primary care clinician. When this occurs the results is overall improved health which means less inpatient care and emergency room visits. The placement of on-site mental health staff at the health care clinic is a major step toward health care integration. It also provides a unique

opportunity for outreach to our Latino Community. Primary care is safe acceptable setting where mental health services can be introduced in a non-stigmatize setting.

### Forensic Services

Jail mental health services are razor thin. The amount of psychiatry time is never able to assess the number of inmates awaiting an interview. There is little time given to a true triage of needs. Medical staff report that newly incarcerated individual who is simply anxious seems to be the same priority as people with psychotic systems. Clients who are stabilized in the jail are discharged without clear follow-up plans or mental health appointments. This report does not include a full assessment of forensic services. However, a few recommendations seem obvious. The County should consider a way to increase the required health care in the jail to include the necessary mental health services. This should include a MOU to ensure people treated in the jail have a follow-up plan and appointment with mental health upon discharge. The reentry program being funded through MHSIA Innovations will certainly be effective in reducing incarcerations in jails and hospitals. Most counties have found that coordinated care reduces the recidivism caused by mental health and substance abuse clients losing the simple gains clients made while incarcerated. Coordinated care could be established by regularly staffing a list of inmates who are about to exit jail. A reentry plan that includes primary care, mental health and substance use services will result in the most successful community outcomes.

### Children and Youth Services

The prevention outreach to schools is to be commended and is still evolving. The staff could use an organized referral process. It was not clear how staff identify youth who require early interventions. The availability of Therapeutic Behavioral Services could use some clarification between the Rebekah Children Services provider and SBCBH Children's' staff. The staff could benefit from an assessment tool to determine when this level of care is indicated. It was generally felt that this level of care could help avoid youth out of county hospitalizations. Client and Family Teams (CFT) meeting do occur but active participation from Child Welfare Services (CWS) could use improvement. The staff of both of these county children resources would improve with an introduction. A periodic social gathering of children's mental health staff and CWS would give both programs a chance to meet each other in a causal setting that would likely lead to better communication and coordination. These gatherings should be followed by regularly

scheduled trainings and procedures that outline both the responsibilities of CWS and SBCBH.

There did not appear to be much if any In Home Based Services (IHBS). This is a valuable resource in assessment and behavioral intervention with the family as partners in the ever evolving treatment process. Trauma Influenced Treatment and other evidenced based practices should lead the way in this development. The new contract with well-respected Seneca Organization will significantly expand the options for both youth and their families. It will take some practice with the SBCBH to facilitate the consistent use of this new resource. A clear path to IHBS would be helpful for staff along with a regular case review of how outcomes were improved with this service. When children are receiving these In Home Based Services (IHBS), it would be beneficial to establish a care coordination plan that includes Hazel Hawkins staff. Making sure the medical team have the most current clinical information as well the crisis plan developed by the SBCBH/Seneca team.

Staff would have to be available in the evening and or weekends to be able to work with families on their terms. I recommend a regular PM shift or perhaps a 4-10 shift that would include evening hours. There is a general sense from my interviews that local mental health is a 9-5 operation. This issue also came up in my discussions with the Hollister Police. They are generally supportive of the mental health staff. However, there was a feeling that the mental health agency shuts down at 4:00. A PM Shift would keep professional mental health staff as the first contact for a mental health crisis instead of law enforcement. It is difficult for all small counties to organize responsive resources for specialized populations. The few number of children needing assessment for inpatient resources means that staff are rarely prepared to offer an effective response to a psychiatric emergency for younger clients. Several parents reported to me that children taken to Hazel Hawkins were either left alone or in room one or manipulated their way to rewards that seem to reinforce problematic behavior. A small county emergency room is rarely prepared for a child in a psychiatric crisis. Parents report that medical staff frequently suggested they were “bad parents” when children exhibited symptoms of a rage disorder. The County should use every resource to avoid a police intervention that results in what will always be an extended stay in room one while very limited children resources are sought in the Bay Area. As reported earlier and especially for children, the county should abandon the practice of only visiting clients in room one at Hazel Hawken’s every 24 hours. A regular follow-up and intervention with a frightened youth being held in the ER is not only reasonable but could result in an earlier discharge to a lower level of care.

Early identification, intervention and preparations of a crisis plan with parents as partners should always be the preferred path to inpatient hospitalization. At the first signs of family distress, a meeting should be arranged to plan alternative strategies with family members as full partners in the treatment team. As part of this plan, primary care physicians, and school counselors should all be made aware of EPSDT resources and how to access them.

From the few extraordinary children cases parents have shared with me it appears the schools resource people and law enforcement could use training on de-escalation techniques as well as who would be available at local mental health to make a school or homebased intervention. More effort and resources should be organized to keep children in their homes while additional resources are organized. In home services such as Therapeutic Behavioral Services (TBS) now available through a community provider are an essential tool to assist parents. Simple strategies developed with parents can offer effective tools for in home strategies. The goal is to deliver services and supports within the least restrictive, most normative environments that are clinically appropriate. Interventions should be designed that are family driven and youth guided, with the strengths and needs of the child and family determining the types and mix

If after all of our efforts to keep a child at home are exhausted the county should implement a plan to have a trained mental health staff person intervene regularly with the child and parents while they await placement.

### Key Recommendations

#### **The current caseload structure does not permit the focus necessary to significantly impact the highest need clients in Full Service Partnerships**

- *I suggest a group of FSP case managers whose focus would be on this exclusive group of clients with a history of repeated hospitalizations. To maximize the impact, this would require a smaller case load of 8-10 FSP clients.*

#### **There are few midrange resources for clients to avoid psychiatric hospitalizations**

- *In terms of resources, both the adult and youth teams could use a consistent access to a social model residential alternatives to hospitalization. I recommend we add social model Crisis Residential. I would recommend 2 beds for adults and one for youth. The small number of youth will only permit a “fee for service” contract.*

- *Another tool to add that would assist clients to regain their composure in a crisis is sometimes referred to as a “warm room”. The Crisis Residential provider should be considered as a resource for this service. A small amount of additional staffing could be added in the 24 hour facility to offer a “warm room” for upset clients in order for them to return to their normal level of functioning.*

### **The established 5150 process creates unnecessary trauma and hampers a more accurate in-community assessment**

- *I recommend when possible a 5150 assessment be completed at the clients place of residence or in a clinical setting with the mental health staff providing transportation as needed. This could begin as day time process with a PM shift added once the day time process is practiced with some success.*

### **Psychotherapist often do not have the best temperament or established client relationships to provide the most thorough 5150 assessment.**

- *The 5150 assessments should be assigned to the case management unit. Honing a specific team of professionals whose role is to intervene in a mental health crisis, deescalate the situation and design a community based plan to avoid a hospitalization can be quite effective. Case Managers, who are comfortable with field work could evaluate the person at their residence. In my opinion, these type of on-site assessments provide the evaluator with a real life survey of the client’s resources and state of wellbeing.*

### **Leaving a person in a psychiatric emergency isolated in a strip down hospital room adds to their trauma and gives little opportunity for them to stabilize**

- *ER staff reported that county mental health staff only visit or reassess a client they have left in the ER once every 24 hours. This practice should be changed and turned into a procedure that outlines an assessment of the client at the change of shifts. I would also recommend an established follow up visit by the case manager or 5150 assessor to determine if a discharge to a lower level of care is warranted.*

- *Establish a follow up client intervention at HHH by a SBCBH clinician to determine if a discharge to a lower level of care is warranted. I recommend a consistent mental health staff person or two be assigned. This liaison could also provide regular follow up and training with HHH staff.*

### **On-call staff often do not often have the time to locate and obtain an elusive psychiatric bed**

- *Establish a “hospital liaison” to keep track of existing psychiatric inpatient and social model resources. This important role can be administrative, saving limited clinical resources. In my experience, the relationships created by this function can be very effective in obtaining results with these very limited resources.*

### **People with complex health needs cannot make effective use of these essential resources when they have inadequate or no housing**

- *Housing is health care, the county should continue to seek additional special needs housing. The needs for addition “no income housing” should be at the forefront of county and city housing efforts, so that Behavioral Health is shovel ready when the opportunity for expansion presents itself.*

### **An effective and available psychiatric medical team is negatively impacted by short term staff and the demands of incarcerated individuals with a mental health need.**

- *Increase nursing time, create competitive salaries and add an e-prescribe module for tele-psychiatry.*
- *The County needs jail psychiatry consultation. SBCBH should establish a follow up plan and medication appointment for clients being released from jail.*
- *These recommendations could be accomplished with an updated MOU and Procedures.*

### **Coordination of care with Hazel Hawkins Hospital needs improvement. An opportunity to improve outcomes is being missed without an established case review process.**

- *Create a monthly meeting (Grand Rounds) at HHH to review common cases both those with successful outcomes and those with problems. Share on-site medical information from Anazasi with the treating physician. Encourage HHH to either*

*contract for a psychiatric consult or place the San Benito County Psychiatrist on staff. Rework the very dated 1999 MOU between HHH and SBCBH.*

### **Current 9-5 staff schedules give little opportunity to interact and plan with parents**

- *Staff should be available in the evening or on weekends to be able to work with families on their terms. I recommend a regular PM shift or perhaps a 4-10 shift that would include evening hours*

### **The small county youth population numbers makes finding emergency psychiatric resources near to impossible. Every effort should be made for early identification and intervention**

- *More effort and resources should be organized to keep children in their homes while additional resources are organized. A children's/youth case conference should be established to review and staff the most at risk cases. The at home, in school mantra should be part of the agency's leading philosophy. I recommend delivering services and supports within the least restrictive, most normative environments that are clinically appropriate. In-Home Services should be readily available that are family driven and youth guided. I recommend that the strengths and needs of the child and family determine the types and mix of services and supports provided*
- *The school based staff could use a more organized referral process. The staff need a method to prioritize which children are afforded more intensive services. A specific tool to determine when this level of care is needed should be created between the county, the schools and it's TBS and Home Based Services provider.*
- *If after all of our efforts to keep a child at home are exhausted the county should implement a plan to have a trained mental health staff person intervene regularly with the child and parents while they await placement.*



**Serial 5150's are a misuse of the authority given to us when we suspend a person's civil liberties in an attempt to provide necessary involuntary treatment.**

The Key to the reductions or elimination of serial detentions is not a single action. It is the combination of all these recommendations that must begin with a philosophical imperative from county leadership that starts with each new employee orientation. The Philosophy must clearly state that clients of the mental health system are most often cared for at home in the least restrictive environment. It must be understood that involuntary treatment, in all its shades is a last resort, temporary measure that at best keeps the client safe and permits complicated medication adjustments, while providing a moment of respite to family members and care givers. The "real" interventions that promote health begin with early interventions and transitions back to community living. This philosophy should be reinforced with staff orientation, trainings and imbedded in all relevant contracts for services. It should also guide the future development of services. As part of this philosophy client choice for all at risk clients should be included in health directives when the client is able to voice their treatment preferences

### *Training*

- *Any mental health provider designated by the BHS Director should receive an annual training on the 5150 process that should include a philosophy of diversion and a knowledge of resources. Whenever possible this training should include the triangle of professionals who are the corner stone of this process, Mental Health, Law Enforcement and Hazel Hawkins.*
- *While the County is not responsible for the Hospital employees, providing a regular training, outlining client rights and mental health symptoms would be advantageous to create an improved client experience in Hazel Hawkins Hospital I recommend this training include the basics of the LPS process*
  - *At the end of 72 hours, if someone has been on a 5150 hold and still meets one of the three criteria (e.g. danger to self, others, or gravely disabled) then the attending psychiatrist can file a 5250, or "certification for up to fourteen days*

*of intensive psychiatric treatment". By law the client must receive a copy of this certification.*

- The client is entitled to an automatic hearing called a certification review hearing, which is informal and a Patients' Rights Advocate from the Patients' Rights Advocacy office represents the consumer.*
- The client can also request a Writ of Habeus Corpus hearing at anytime to contest being held in front of a judge*
  
- The schools resource people and law enforcement could use a training on de-escalation techniques. This training should include refreshers on local mental health resources including homebased interventions.*
  
- A social gathering of children's mental health staff and CWS would give both programs a chance to meet each other in a causal setting that would likely lead to better communication and coordination. This gathering should be followed by regular scheduled trainings to inform our partners of our services and procedures for our shared CWS cases.*