

SHASTA COUNTY MENTAL HEALTH, ALCOHOL AND DRUG ADVISORY BOARD (MHADAB)
REGULAR MEETING
Minutes
July 6, 2016

Members: Steve Smith, Marcia Ramtrom, Charlie Menoher, Kari Hess, Marvin Peterson, David Kehoe, Michele Wright, Leon Polk, Sam Major, and Ronald Henninger

Absent Members: Janet Rudd, Sonny Stupek, and Dave Kent

Shasta County Staff: Donnell Ewert, Dean True, Dianna Wagner, Jamie Hannigan, Cara Schuler, Liz Leslie, Marc Dadigan,

Guests: Andrew Thompson, Bob Thompson, Jason Kletter, Art Sevilla, Marjeanne Stone, Shari Calloway, Sue Gustafson, Steve Lucarelli, Susan Wilson, Kara Rogge, Alex Dodd, Taylor Thompson, and Erin Michaels

Agenda Item	Discussion	Action	Individual Responsible
I. Introductions	<ul style="list-style-type: none"> ➤ Chair extended a warm welcome to all attendees. ➤ Board members and HHSA staff introduced themselves. 		<ul style="list-style-type: none"> ➤ Steve Smith, MHADAB Chair
II. Public Comment Period	<ul style="list-style-type: none"> ➤ None. 		
III. Provider Reports	<ul style="list-style-type: none"> ➤ None. 		
IV. Approval of Minutes	<ul style="list-style-type: none"> ➤ Minutes from the May 4, 2016 meeting were presented in written form. 	<ul style="list-style-type: none"> ➤ Approve the May 4, 2016 minutes as submitted. 	<ul style="list-style-type: none"> ➤ Charlie Menoher (Motion) David Kehoe (Second)
V. Announcements and Review of Correspondence	<ul style="list-style-type: none"> ➤ Chair went over a letter received from California Mental Health Planning Council – Patients’ Right Committee. Board members were sent the letter to review prior to the meeting. Jill Ward, Shasta County Patients’ Rights Advocate gave a presentation November 2015 to the Board and this covers the item in the letter. 		<ul style="list-style-type: none"> ➤ Steve Smith, MHADAB Chair
VI. MHSA Update	<ul style="list-style-type: none"> ➤ <u>COMMUNITY MENTAL HEALTH RESOURCE CENTER:</u> Hill Country Health and Wellness Center was chosen as the provider. On June 21, 2016, a contract negotiation meeting was held and several other meetings will be held to continue working out the details; looking at an opening of December 2016 to January 2017. The location will be in the downtown Redding area. ➤ <u>WOODLANDS PROJECT:</u> If you drive by the project on Ellis Street, walls are going up. ➤ <u>EASTERN COUNTY HOUSING PROJECT:</u> Two community meetings have taken place (May 24 and June 21, 2016). Both were highly attended and quite contentious. Members of the community seemed to think that a facility was going to be built and people who are homeless were going to be bussed from Redding to Eastern County. Community members were reassured 		<ul style="list-style-type: none"> ➤ Jamie Hannigan, HHSA Program Manager and MHSA Coordinator

	<p>that is not the case. There is a need in the Eastern County that already exists and it is for individuals who are currently Eastern County residents. A presentation was done by Tammy Allen, the BH Director of Hill Country and Supervisor of the Full Service Partnership (FSP) Program, which is related to the housing. Several of the community members do not think that there are mental health services in the area. A list of mental health services and places you can go in Eastern County were given out. A participant from Circle of Friends spoke about her experience and the changes that have happened in her life since she became an FSP; a couple others spoke about the supportive environment and what that means to their wellness and recovery. NVCCS and the County gave presentations about what kind of project they are looking for. Another meeting will be scheduled once NVCCS brings a project forward.</p> <p>➤ WORKFORCE EDUCATION AND TRAINING: In June, the Board of Supervisors approved a new employee classification called Peer Support Specialist. Positions will be available for individuals to use their lived experience with mental illness in order to provide peer mental health services. The position will work in mental health programs and provide support for the residents of The Woodlands, CRRC, The STAR Team and Outpatient Services.</p> <p>➤ MHSA WEBSITE: A lot of information has been added to the MHSA website. You can visit the site at www.shastamhsa.com. Please provide feedback on usage and what people think as we continue to modify website.</p>		
VII. Action Items	<p>A. Open Public Hearing to receive comments on the MHSA Fiscal Year 16/17 Annual Update; close Public Comment Period; and close Public Hearing (as required by California Code of Regulations, Title 9, section 3315A).</p> <ul style="list-style-type: none"> • MHSA Coordinator advised that the Ad Hoc Committee met (Ron Henninger, Sam Major and Steve Smith) prior to opening of public comment period. The Ad Hoc Committee had changes and suggestions, which were incorporated. Children’s Branch was asked to re-write the Positive Action and Triple P sections to give some additional information. Public comment period opened and to date four comments were received. All were 	<p>A. Public Hearing opened to receive comments on the MHSA Fiscal Year 16/17 Annual Update. Public comment period closed and public hearing closed.</p>	<p>➤ Jamie Hannigan, Program Manager, MHSA Coordinator</p>

	<p>positive. The MHADAB Executive Committee met on June 20, 2016 and discussed the report. The Committee made requests for changes on Triple P to re-write on specific information on the Performance Improvement Plan, address the progress on the four areas concerned that were identified in last year's Annual Update and strategies for continuing and the progress made. The re-write was completed today and the Ad Hoc Committee received and have approved the changes as well as the Positive Action changes. The changes made today will be incorporated into the document before it goes to the Board of Supervisors (BOS). Discussion took place on Triple P.</p> <ul style="list-style-type: none"> • Member Henninger had questions on the FSP Program. He would like to see how many clients drop out in the first year. He understands the data shows clients who have completed one year. How many clients start the program and fall out? If the program is only serving 169 clients, is there a way to expand the service to a greater population? MHSAs Coordinator responded to member Henninger's questions and offered to schedule a meeting to go over the reports. • Member Kehoe appreciates and values the tenacious approach that the Board is embracing as far as program review is concerned. He would welcome hearing from the Ad Hoc Committee and the Executive Board as to whether there are any supplemental observations to make. The Ad Hoc Committee and the Executive Board commented. • Member Kehoe also suggested that the Board broaden their inquiry and look at the contracts. Most contracts that the County signs with providers including those with the State of California are activity based contracts rather than results oriented contracts. It is imperative that we look at results. <p>B. Review and consider recommending adoption of the MHSAs Fiscal Year 16/17 Annual Update to the Shasta County Board of Supervisors.</p>	<p>B. Recommend the Board of Supervisors adopt the MHSAs Fiscal Year 16/17 Annual Update.</p>	<ul style="list-style-type: none"> ➤ Ron Henninger, MHADAB Member ➤ David Kehoe, MHADAB Member/Board of Supervisor ➤ Leon Polk (Motion) Sam Major (Second) David Kehoe (Abstained)
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	<p>C. Consider taking position on the City of Redding's Sales Tax Measure on the November 2016 Ballot.</p> <ul style="list-style-type: none"> • HHS Director explained the two measures – The City of Redding has put two measures on the ballot. One is a ½-cent sales tax of a general nature, which requires 50%+1 passage rate. There is a second measure on the ballot, which is an advisory measure which advises the City Council how to spend the money and then outlines the things that the public would demand that the City Council spend the money on. However, the City Council is not bound to do that. The City Council in the meantime has already decided they are already going to assist the Oversight Committee; they are going to make recommendation to appoint an advisory committee that will oversee how the money is spent. They believe that the ½-cent sales tax will generate about \$11 million a year and they outline some of the things they want to do with it. The Behavioral Health component is for \$1 million a year for a crisis stabilization unit and a one-time contribution of \$375,000 for a sobering center. The remainder of the funds would be spent on increasing the budget for the Redding Police Department and the Redding Fire Department and providing resources to the County for jail construction or reconstruction once the courthouse is built and the new jail on Breslauer is built and jail is staffed. Discussion took place by the Board. • Member Kehoe read an email he wrote several years ago regarding a potential sales tax increase. • Steve Smith and Kari Hess agreed to work on the Measure. 	<p>C. Approve taking a positive position on the City of Redding's Sales Tax Measure on the November 2016 Ballot.</p>	<p>➤ Charlie Menoher (Motion) Sam Major (Second) Kari Hess (Opposed) Michele Wright and David Kehoe (Abstained)</p>
<p>VIII. Presentations</p>	<p>A. <u>OVERVIEW OF MEDICATION-ASSISTED TREATMENT:</u> A PowerPoint presentation regarding an Overview of Medication-Assisted Treatment was provided by Jason Kletter, Ph.D. – BAART Programs (Bay Area Research Addiction & Treatment) [See Attachment A]</p>		<p>➤ Jason Kletter, Ph.D. President BAART Programs</p>

	<p>B. <u>AEGIS TREATMENT CENTERS:</u> A PowerPoint presentation regarding Aegis Treatment Centers was presented by Alex Dodd. Clients Erin Michaels and Taylor Thompson told their stories of how they ended up at Aegis and going through the recovery process. Bob Thompson, Taylor's father told his story about his son through family member's eyes. Currently, there are 65 clients from Shasta County at Aegis. [See Attachment B]</p>		<p>➤ Alex Dodd, Chief Executive Director Aegis</p>
IX. Directors' Report	<p>➤ The Directors' Report was sent out prior to the meeting for the Board and guests to review. [see Attachment C] Director True provided further information on the Grand Jury report.</p>		
IX. Discussion	<p>A. <u>FISCAL YEAR 16/17 MENTAL HEALTH PERFORMANCE CONTRACT:</u> HHS Director reviewed FY 16/17 MH Performance Contract. The County gets continuous appropriations of 1991 and 2011 realignment and Mental Health Services Act money. The legislature has set in motion automatic payments for those funding streams. This is the accountability sheets for those monies. There are two block grants that the feds give the state. This Performance Agreement outlines the state's expectations and requirements related to those five funding streams and it has to be done every year. There are only technical changes from last year.</p>		<p>➤ Donnell Ewert, MHADAB Chair</p>
XI. MHADAB Standing Committee Report	<p>None</p>		
XII. Other Reports	<p>➤ <u>COMMUNITY EDUCATION COMMITTEE (CEC):</u> Becoming Brave training will take place on Saturday, July 16, 2016 from 10-5 at the Redding Library. The Getting Clean Forum will take place on Monday, July 18, 2016 from 5-8 at the United Methodist Church on East Street. There will be four speakers who have experience with substance use disorders and Opioid addiction. The next Hope is Alive Open Mic Night will take place on August 5, 2016 from 6-7:30 at the Good News Rescue Mission.</p> <p>➤ <u>SUICIDE PREVENTION WORKGROUP:</u> According to the CDC, suicides increase significantly from 1999 to 2014. It used to be a life was lost every 18 minutes, it is now every 12 minutes. The Out of the Darkness Walk will take place September 12, 2016.</p>		<p>➤ Marc Dadigan, Community Education Specialist</p> <p>➤ Steve Smith, MHADAB Chair</p>

	<ul style="list-style-type: none"> ➤ <u>ADP PROVIDER MEETING:</u> No meeting has taken place. The next meeting is August 17, 2016 at 10:00 a.m. at the Library. ➤ <u>HOMELESSNESS MEETINGS:</u> Member Major advised that the Strategic Plan meeting has been postponed until July 13, 2016 at 5:30 pm at the Red Lion. ➤ <u>CALIFORNIA ASSOCIATION OF LOCAL BEHAVIORAL HEALTH BOARDS/COMMISSIONS:</u> Member Polk advised that he was voted in as one of the members for the Superior Region. He recently attended a meeting in San Bernardino County. 		<ul style="list-style-type: none"> ➤ Sam Major, MHADAB Member ➤ Leon Polk, MHADAB Member
XIII. Reminders	➤ See Agenda.		
XIV. Adjournment		➤ Adjournment (7:51 p.m.)	

Steve Smith, Chair

Cara Schuler, Secretary

Medication-Assisted Treatment

A Presentation to Shasta County Mental Health,
Alcohol and Drug Advisory Board
July 6, 2016

Jason Kletter, Ph.D.
Bay Area Addiction Research and Treatment
(BAART)



The Opioid Epidemic

National And Local Data



Prescription Analgesic Problem

Of the 21.5 million Americans 12 or older that had a substance use disorder in 2014, **1.9 million** had a substance use disorder involving **prescription pain relievers** and **586,000** had a substance use disorder involving **heroin**.

- Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2015). Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available at <http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf>.



[3]

Prescription Use → Heroin Use

- The number of people who started to use heroin in the past year is also trending up. Among new heroin users, **approximately three out of four report abusing prescription opioids prior to using heroin**.
- The increased availability, lower price, and increased purity of heroin in the US have are contributors to rising rates of heroin use.
- Heroin-related deaths more than tripled between 2010 and 2014, with 10,574 heroin deaths in 2014.
- The largest increase in overdose deaths from 2013 to 2014 was for those involving synthetic opioids (excluding methadone), which rose from 3,105 deaths in 2013 to 5,544 deaths in 2014. One of these synthetic opioids, illegally-made fentanyl, drove the increase. It was often mixed with heroin and/or cocaine as a combination product—with or without the user's knowledge.



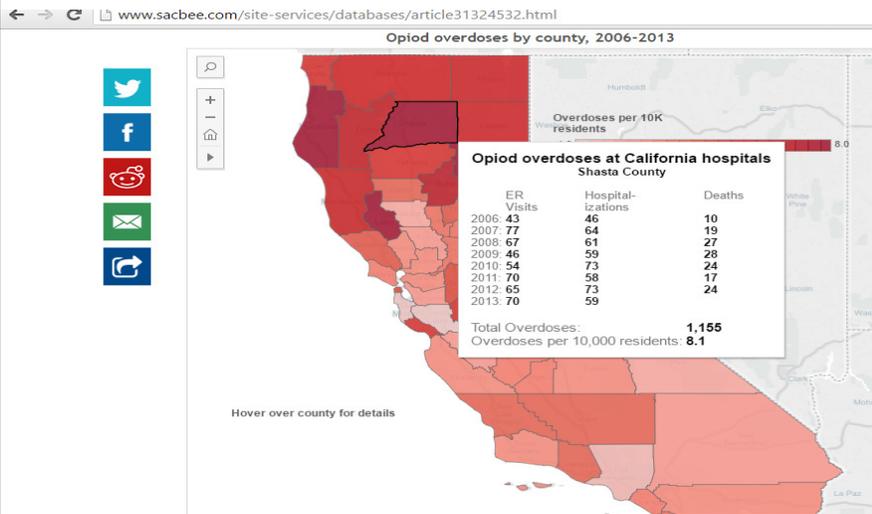
Opioid Epidemic

- Deaths from drug overdoses have jumped in nearly every county across the United States, driven largely by an explosion in addiction to prescription painkillers and heroin.
- Since 1999, the amount of prescription opioids sold in the U.S. nearly quadrupled, yet there has not been an overall change in the amount of pain that Americans report. Deaths from prescription opioids—drugs like oxycodone, hydrocodone, and methadone (prescribed for pain)—have also quadrupled since 1999.
- The number of these deaths reached a new peak in 2014: **47,055** people, or the equivalent of about 125 Americans every day.



Shasta County Overdose Data

Source: California Department of Public Health



HEROIN IN SHASTA COUNTY

NUMBER OF MEDI-CAL PATIENTS TREATED IN SHASTA COUNTY FOR HEROIN USE

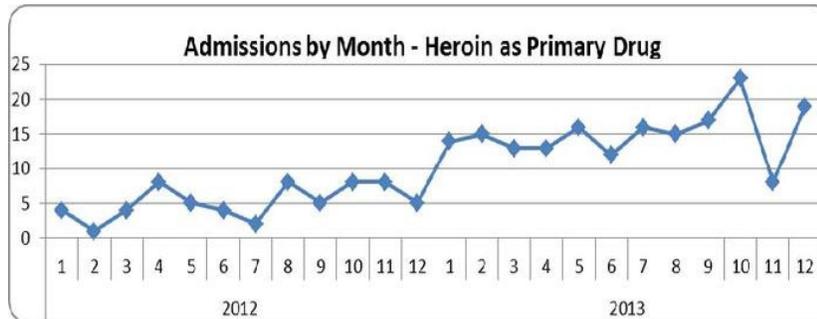
2008	2013
50 (heroin among drugs used)	218 (heroin among drugs used)
29 (heroin primary drug used)	129 (heroin primary drug used)

MAIN DRUG AS PERCENT OF ADMISSIONS IN TREATMENT CENTERS

2008	2013
37.4% - meth)	42.3% - meth)
35.1% - alcohol)	17.7% - alcohol)
16.7% - marijuana)	15.3% - heroin)
2.3% - heroin)	9.7% - marijuana)

Source: California Department of Alcohol & Drug Programs

In 2012, heroin admissions to Shasta County treatment centers averaged **5.2 per month**, while in 2013 they averaged **15.1 per month**



The average number of heroin users entering treatment each month in Shasta County essentially tripled year over year, with the upward trend continuing throughout 2013.

Source: California Department of Alcohol & Drug Program's California Outcomes Measurement System (CalOMS)



The Science of Addiction And Efficacy of Opioid Treatment

What Do We Know And What Works



Addiction is a chronic, relapsing
brain disease

- Treatable, but not curable
- There is a wide spectrum of severity and readiness
- Retention in treatment is key
- Best treatment is individualized and integrated



[10]

National Institutes of Health

- NIH Consensus Statement on the *Effective Medical Treatment of Opiate Addiction*, 1997
- “Statement provides state-of-the-art information regarding effective treatments for opiate addiction and presents conclusions and recommendations...”



NIH Consensus Statement, cont.

- Evidence that Opioid Dependence is a Medical Disorder: (Not a problem of motivation, willpower, or strength of character)
- “Continuous exposure to Opioids induces pathophysiologic changes in the brain.”



[12]

NIH Consensus Statement, cont.

“Opiate Dependence is a brain-related medical disorder that can be effectively treated with significant benefits...”



[13]

Methadone History and Efficacy

- Developed as a treatment for opiate addiction in the 1960's.
- Widely and empirically studied
- Effectiveness demonstrated in a consistent & replicable manner for over five decades



[14]

Opiate Treatment Programs In The United States

- 350,000 patients
- 1,400 Clinics
- Multidisciplinary teams including Physicians, nurses and counselors
- Closely regulated by Federal, State agencies
- Accredited



[15]

Narcotic Treatment Programs in California

- 40,000 patients
- 140 Clinics
- Multidisciplinary teams including Physicians, nurses and counselors
- Highly regulated by Federal, State agencies
- Accredited



[16]

Comparing Two Opioid Agonists: Methadone and Heroin

Methadone	Heroin
Orally effective. No risk of infection.	Injection use is a risk factor for transmission of infectious diseases.
Long acting. Administered once a day.	Short acting. Must be administered several times a day.
Causes no sedation or euphoria.	Can cause significant sedation and/or euphoria.
Prescribed by a physician in context of medical care	Obtained illegally with suspect ingredients

Opiate Treatment Program Goals

● Primary Goals:

- Reduction in of illicit opiate use and licit opiate misuse.
- Retention in treatment.

● Secondary Goals:

- Reduction in cocaine, alcohol, and other drug abuse.
- Reduction in transmission of infectious diseases by unsterile injection equipment.
- Reduction in criminal activity.
- Increase in pro-social activity — employment, education, child care, etc.



[18]

Treatment Requirements

- Attendance for observed dosing 7 days a week for the first 90 days
- Take-home doses permitted after 90 days but only to those patients meeting a number of criteria
- At least once per month drug testing
 - Some clinics observe collection; some don't
 - Some agencies administer alcohol breath tests; some don't
- At least once per month counseling
- Additional education, i.e., HIV/HCV, family planning
- Medical care



[19]

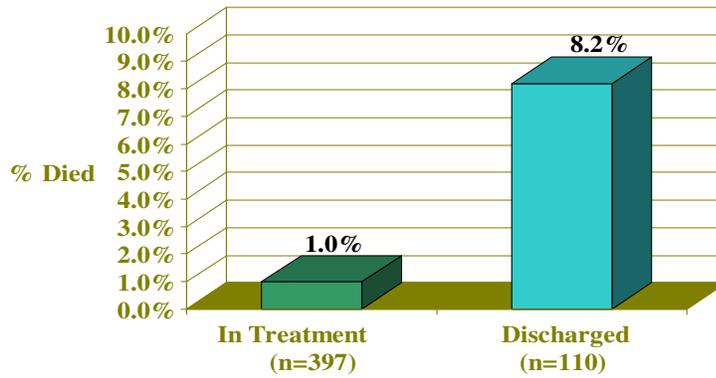
Efficacy of Treatment

Evidence from the Literature



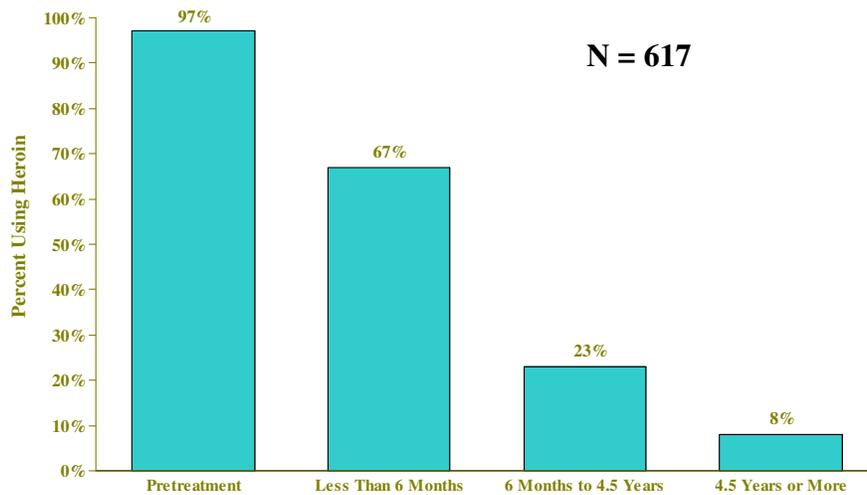
Mortality Rates in Treatment and 12 Months after Discharge

Zanis and Woody, 1998



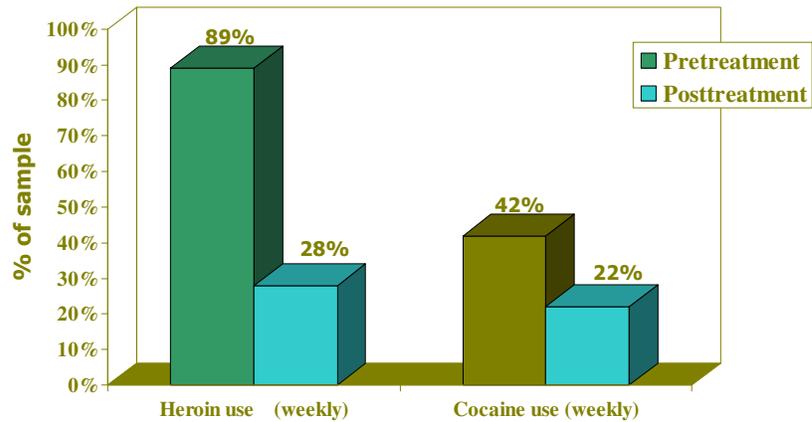
Reduction of Heroin Use by Length of Stay in Methadone Maintenance Treatment

(Ball and Ross, 1991)



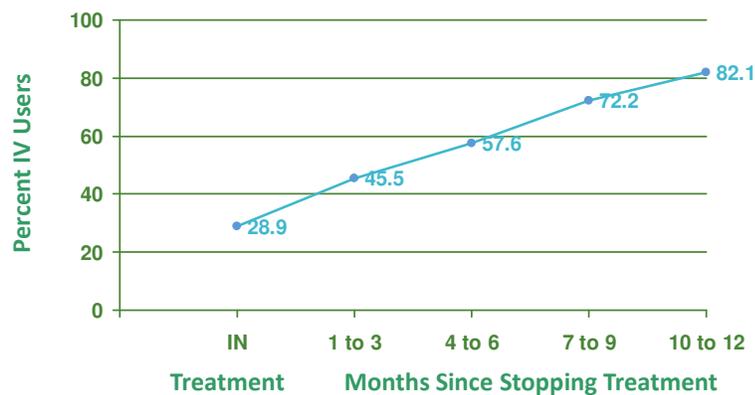
Methadone Treatment Efficacy

n=727, Hubbard et al. 1997



Relapse to IV Drug Use After MMT

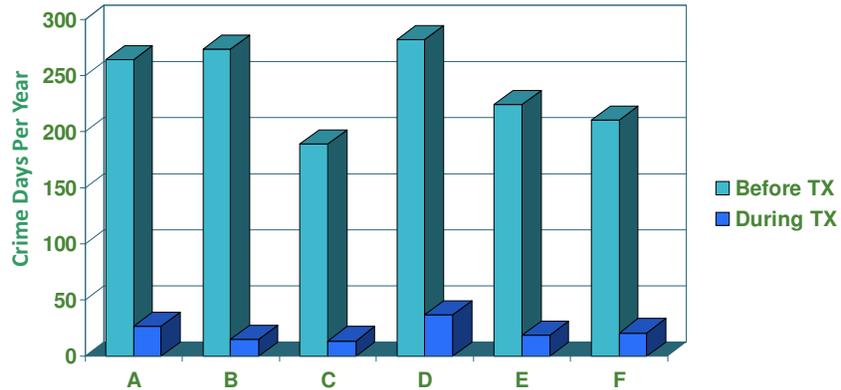
105 Male Patients Who Left Treatment



Adapted from Ball & Ross - *The Effectiveness of Methadone Maintenance Treatment*, 1991

Opioid Agonist Treatment of Addiction - Payte - 1998

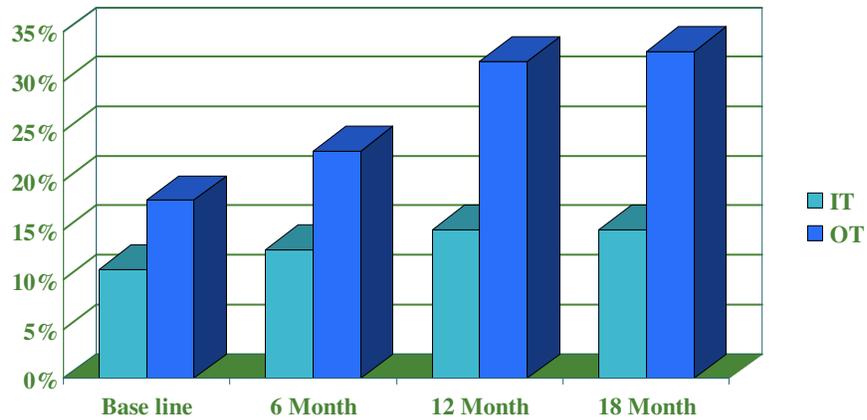
Crime Among 491 Patients Before and During MMT at 6 Programs



Adapted from Ball & Ross - The Effectiveness of Methadone Maintenance Treatment, 1991

Opioid Agonist Treatment of Addiction - Payte - 1998

HIV conversion in treatment



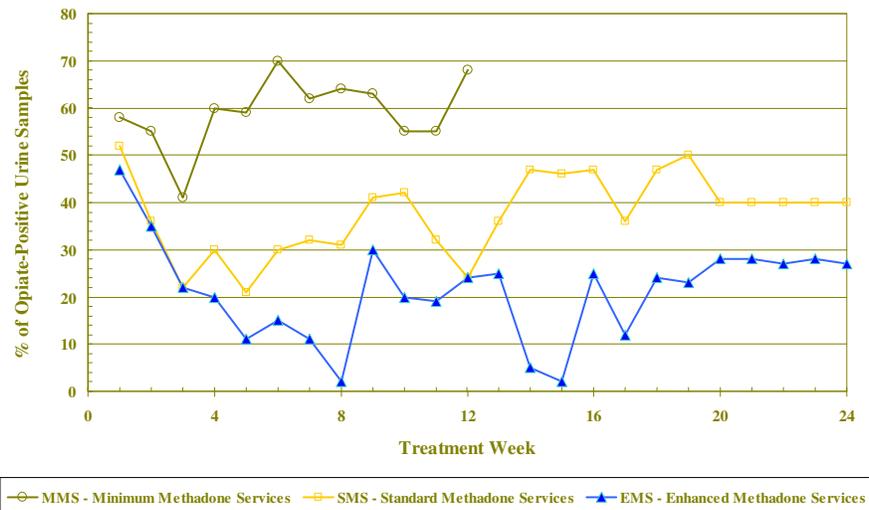
HIV infection rates by baseline treatment status. In treatment (IT) n=138, not in treatment (OT) n=88

Source: Metzger, D. et. al. J of AIDS 6:1993. p.1052

Opioid Maintenance Pharmacotherapy - A Course for Clinicians - 1997

Role of Psychosocial Services in Reducing Illicit Opioid Use

(Adapted From McLellan et al., 1993)



A FEW WORDS ABOUT BUPRENORPHINE

- Safety profile (ceiling effect)
- Schedule 3 (methadone is 2)
- Displaced other opiates: withdrawal on induction
- Sublingual tablet/film
- One form combined with naloxone
- Office – based use available but no requirement for supportive services and no oversight
- Cost factor



[28]

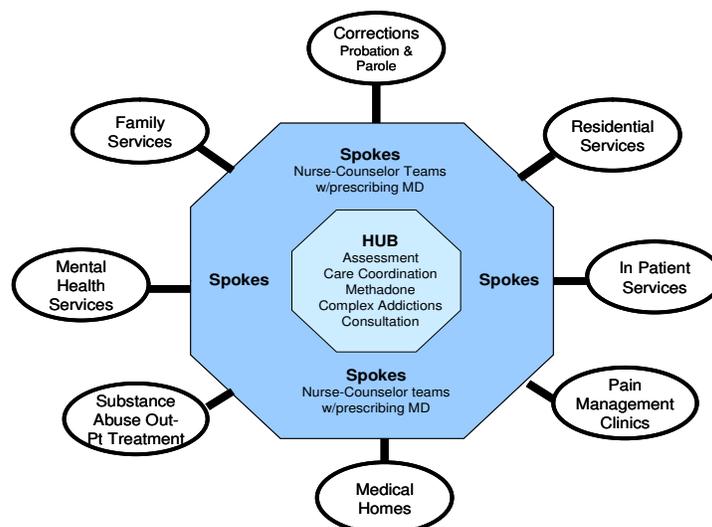
Treatment Outcome Data Summary

- 8 fold reduction in death rate
- Reduction of drug use
- Reduction of criminal activity
- Engagement in socially productive roles; improved family and social function
- Increased employment
- Improved physical and mental health
- Reduced spread of HIV
- Excellent retention



[29]

Hub-And-Spoke Model

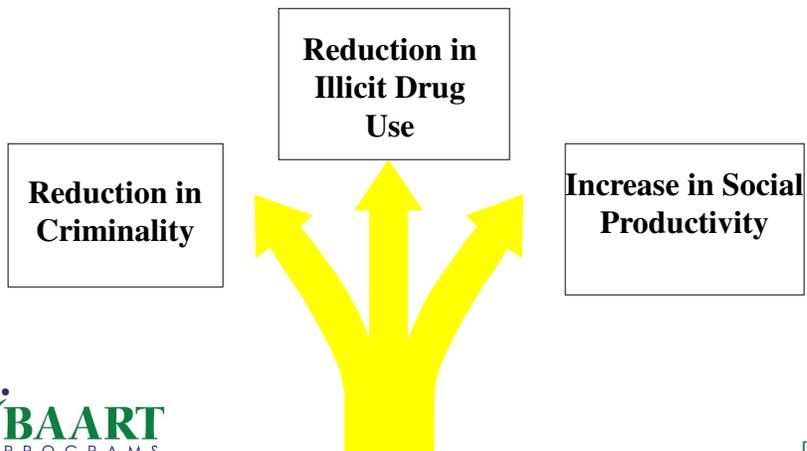


Vermont Department of Health

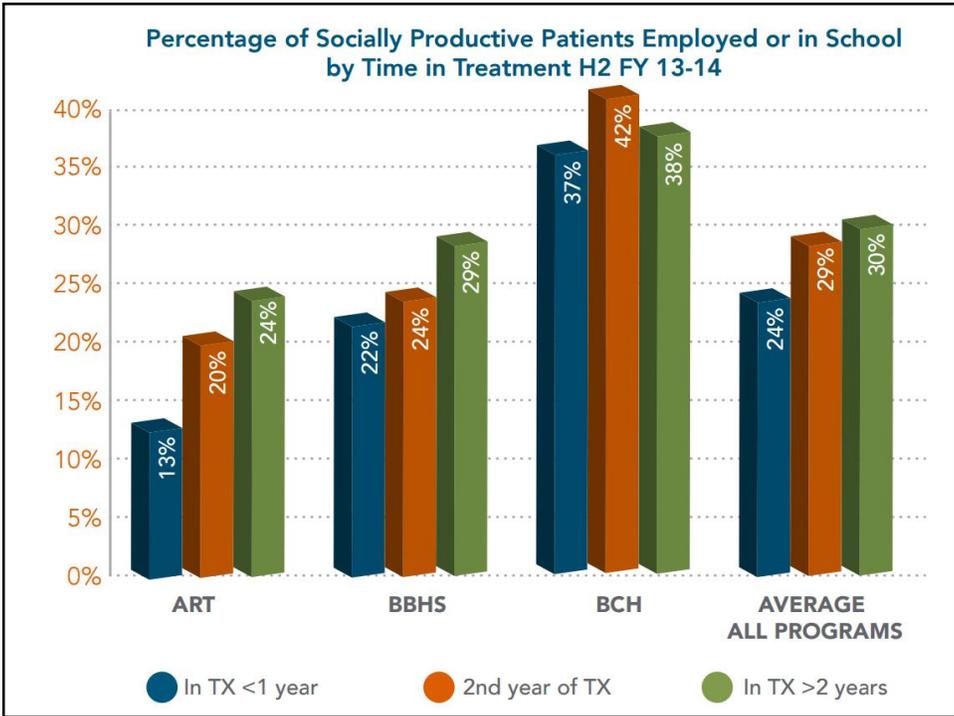
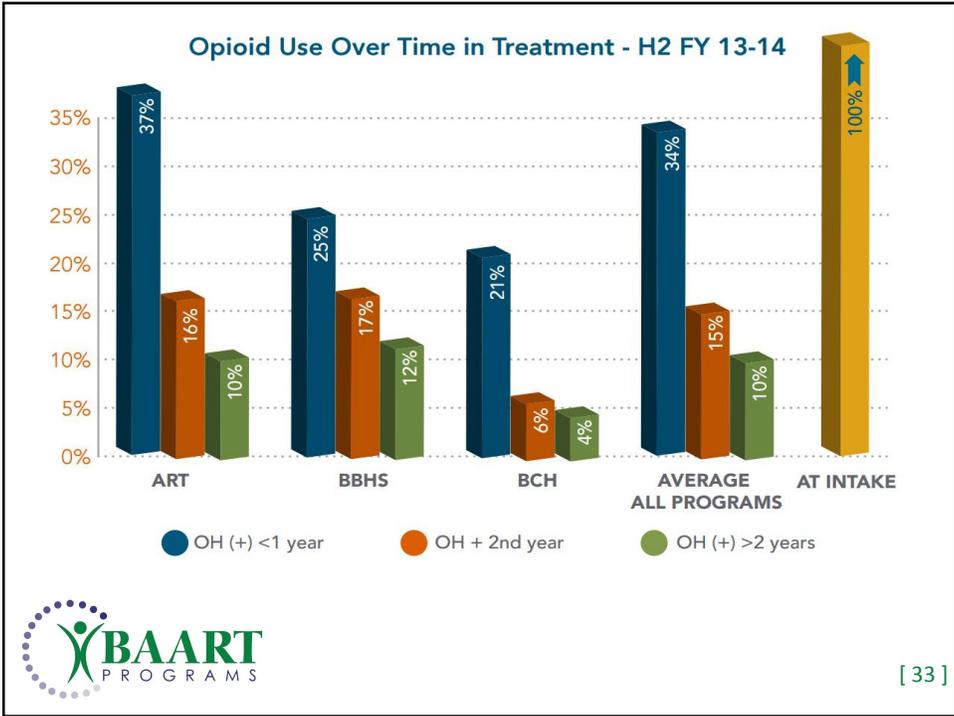
BAART Outcome Data and the Impact of Counseling



Common Outcome Measures “The Big Three”



[32]



Assembly Bill 2071

- California Legislature (1997)
- Requires minimum amounts of counseling to be received by patients in methadone treatment
- Increase from no measurable minimum to a minimum of 50 minutes per patient per month (up to 200 minutes)



[35]

Counseling and Drug Use

Study: By Evan Kletter, Ph.D.

- Identified a group (179) of BAART patients and looked at their UDS one year prior to AB2071 (July 1996-June 1997) and two years after AB2071 (July 1997-June 1999)
- Hypothesized that drug use would decrease due to an increase in counseling



[36]

Counseling and Drug Use

Study: By Evan Kletter, Ph.D.

	Pre AB 2071	Post AB 2071	CHANGE
Average Cocaine Positive UAs	69.2 (17.8)	42.6 (29.8)	26.5 (28.9)
Average Heroin Positive UAs	65.5 (23.4)	36.1 (29.0)	28.9 (29.5)



Counseling and Drug Use

Study: By Evan Kletter, Ph.D.

- **Negative Correlations were found between:**
- Counseling units and Cocaine use
Units (1 unit=10min.)
- Counseling units and Heroin use
- Number of sessions and Heroin use

As Counseling increases, Drug Use decreases



Evidence Of Cost Effectiveness



[39]

Cost Effectiveness

- Research Triangle Institute study on methadone lifetime benefit of \$38 Return on Investment
<http://www.rti.org/news.cfm?nav=493&objectid=756AD336-5498-4C80-8694A1F1186E5381>
- In 2005 UCLA updates the CALDATA cost/benefit study reconfirming \$7 benefit for every \$1 spent
<http://www.universityofcalifornia.edu/news/article/7601>



[40]

NIH Consensus Statement Conclusions



National Institutes
of Health

- All opiate dependent persons under legal supervision should have access to methadone maintenance;
- Need for improved training for physicians and other healthcare professionals...in the diagnosis and treatment of opiate dependence; and
- Coverage for opiate agonist treatment programs should be a required benefit in public & private insurance programs.



Shasta County
Our County... Our Community!



**Aegis Treatment Centers
Mental Health, Alcohol & Drug
Advisory Board Presentation
July 6, 2016**

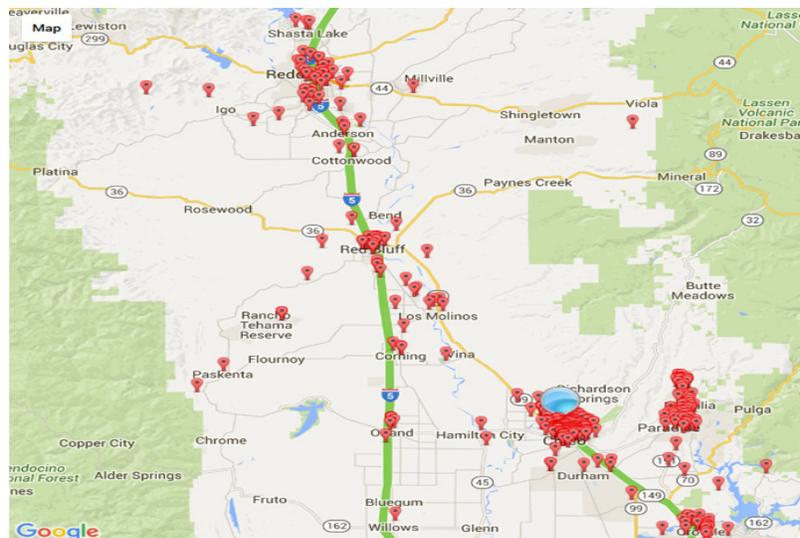
Agenda

- Introduction to Aegis
- Patient Testimonials
- Listening to the Community: Local Impact of the Opiate Epidemic
- What an Aegis Redding Treatment Center Would Look Like
- Q & A

PAAG & Parent Testimonials

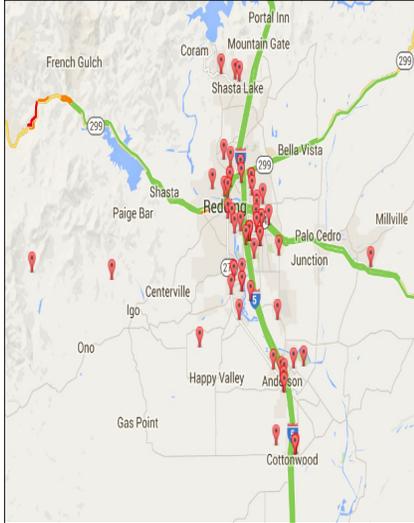
- Erin
- Taylor
- Bob

Mapping of All Active Chico Patients



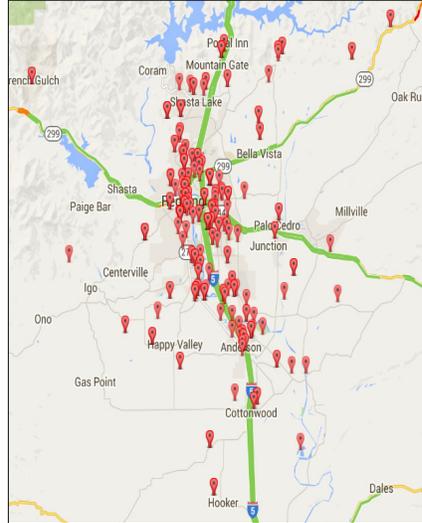
**Mapping of All Active Shasta
County Patients**

66 total Patients



**Mapping of Discharged Shasta
County Patients**

272 Patients from 2011 to 2016 ytd



Listening to the Community...

Understanding the Local Impact of the Opiate Epidemic

Key Meetings with Shasta County Agencies & Providers:

- February 1 Visit to Redding to see key landmarks, locations of county offices/ local providers & get a feel for the community
- February 22 Shasta County Health & Human Services
Shasta County Public Health
- March 28 Tours of the Chico Treatment Center w/ Shasta Co. HHS Staff
- April 25 Redding Chief of Police
Shasta County District Attorney
- May 16 Shasta County CEO & HHS
Shasta County District Attorney
- June 6 Shasta County Sheriff
Redding Chief of Police
- June 20 Good News Rescue Mission
Shasta County Probation

Listening to the Community...

Understanding the Local Impact of the Opiate Epidemic

Planned Events

- July 20 Presentation for the Community Corrections Partnership Executive Committee
- July 22 Shasta Probation Tour of the Chico Treatment Center
- August 17 Presentation for Shasta County Alcohol and Drug Providers
- August 19 Shasta County Team Tour of Chico Treatment Center
- August 24 Panel Discussion with the Governing Board of Partnership HealthPlan of California re: a comprehensive drug treatment system for Shasta County and 7 other counties

What We Think is Unique About Aegis ?

- **Patient Centered Focus**
 - Patient Advocacy and Advisory Group (PAAG) where our patient's voices are heard and shape our treatment model and scope of services
 - Keys to Recovery (K2R) Support Groups where our patients support each other on their roads to recovery
- **Recovery Focus**
 - *Medication is only half of the recovery solution! Counseling is what promotes long-term recovery!*
 - We offer Tapering & Aftercare Groups because we believe that many of our patients can and want to be not only illicit drug free, but medication free too
 - 20% of all patients taper down to a low level of medication while testing illicit drug-free and successfully "graduate" in recovery
 - An additional 15% of all patients are tapering toward their goal of successful graduation
- **Community Involvement**
 - We are very active in our communities, partnering with other providers to improve patients care & access to treatment, educate & reduce stigma
 - 49 meetings & 14 presentations with the community so far this year

Chico Patient's Tree of Life



Chico Aegis Treatment Center



What the Redding clinic lobby and front office would look like



(Lobby of 5225 Telegraph Road, Ventura clinic)

Questions & Answers



Health and Human Services Agency

Donnell Ewert, MPH, Director

Dean True, RN, MPA, Adult Services Branch Director and Alcohol and Drug Program Administrator
Dianna Wagner, MS, LMFT, Children's Services Branch Director

Directors' Report – July 6, 2016 **Mental Health, Alcohol and Drug Advisory Board**

Adult Services Branch Update:

Private Facilities:

The 'upstairs' apartments that are onsite at the Ridgeview facility are now beginning to receive clients. This is a great step forward as it will be a wonderful transition opportunity for people who no longer need a formal Board & Care facility/program, but would continue to benefit from added support.

Mental Health Services Act (MHSA) Innovations Project:

The Request for Proposal (RFP) process for the new MHSA Innovations project, working title 'Community Mental Health Resource Center', is complete, and the contract has been initially awarded to Hill Country Health and Wellness Center. Initial meetings with Hill Country have taken place, and the work of contract negotiation has begun. Both the county and Hill Country staff are excited about the planning and implementation of this exciting project.

MHSA Permanent Supportive Housing Project for the Eastern County:

The selection process for a developer has been completed, and the county will be partnering with Northern Valley Catholic Social Service to provide this wonderful opportunity for those in the Intermountain Area. The county has held two community meetings in Burney to answer questions and address concerns the community expressed once word of the project reached the larger group (MHSA Stakeholder meetings had been held prior to these meetings). Two major issues were raised by select community members: will there be adequate support for individuals receiving housing through this project, and; is it the county's intent to move individuals from the Redding area to the Intermountain Area? During the second community meeting the audience received an excellent PowerPoint presentation from Hill Country regarding the comprehensive services that will be available to individuals living in this housing project. The audience was also assured by Donnell Ewert, HHSA Director that the primary purpose of the housing project was provide permanent supportive housing to individuals who are already residents of their community. Contract negotiation, coordination, and planning will begin soon.

Local Emergency Room Pilot Project:

The County continues with its 'co-location' project in both local hospital emergency rooms. Currently there is one staff at each hospital on both dayshift and evening shift, Monday through Friday. The county continues to recruit for positions that will work on weekends. Anecdotal reports continue to be very favorable: for individuals not needing inpatient psychiatric hospitalization time to evaluation and discharge is shorter.

Shasta Grand Jury Report:

The Shasta County Board of Supervisors approved a response to the Grand Jury report entitled "A Mental Health Crisis, Following the Call, the First 72 Hours Matter" on June 28, 2016. (Please see attached)

Alcohol and Drug Updates:

The quarterly Alcohol Drug Provider meeting was held on May 25, 2016 and had 27 attendees that included County staff, MHADAB members (Steve Smith and Kari Hess), contracted providers and other local providers of SUD services. Highlights include:

- Naloxone – discussion on distribution of approximately 200 naloxone kits made available with SAPT funds. Providers are open to distribution at their agencies if liability concerns are resolved. They are also open to distributing coupons which clients can fill at a local pharmacy. They also suggested talking to Suicide Prevention in order to access family members of people at risk for opiate overdose.
- DMC-ODS Waiver – a lengthy discussion was held on the upcoming waiver, the benefits and challenges for providers, the tentative timeline for roll-out, and upcoming trainings related to the waiver. That was followed by a more in-depth discussion in breakout groups about the preferred local model for case management and recovery services.
- The next ADP Provider meeting will be August 17, 2016 at 10:00 am. at the library

Children’s Services Branch Update:

AB 403 Continuum of Care Reform to roll out January 1, 2017 (Update):

A Northern Regional CCR Leadership Convening will be held at the McConnell Foundation on July 7, 2016 to bring Social Services, Behavioral Health, and Probation leaders together to discuss the needs of the North State in this time of change and how we can collaboratively work together.

Mental Health:

A new Triple P pilot is underway (began July 1, 2016) using the Triple P America On Line Scoring Application, iPads, and our own Electronic Health Record system to streamline the collection of data. This pilot will give our Triple P practitioners a simplified system to collect all data requirements for this evidenced-based program.

Board of Supervisor Staff Reports (May – June 2016):

- Agreement with Mid Valley Providers, Inc. for Residential Care Home Services
- Renewal Agreement with California Psychiatric Transitions Incorporated for Residential Mental Health Rehabilitation Services
- Agreement with Willow Glen Care Center for Community Residential Treatment Services
- Agreement with North Valley Behavioral Health, LLC for Inpatient Psychiatric Services
- Agreement with Dr. John L. Schaeffer, Inc. dba American Telepsychiatrists for Telepsychiatry Services
- Agreement with Butte County for Acute Psychiatric Inpatient Care
- Agreement with Psynergy Programs, Inc. for Specialty Mental Health Treatment Services.
- Agreements with Shingletown Medical Center and Mountain Valley's Health Centers



Shasta County

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June 28, 2016

The Honorable Gregory Gaul
Presiding Judge, Shasta County Superior Court
1500 Court St., Rm. 205
Redding, CA 96001

Dear Judge Gaul:

Re: A Mental Health Crisis, Following the Call, the First 72 Hours Matter

The Shasta County Board of Supervisors appreciates the time and dedication which the 2015-2016 Grand Jurors contributed to their charge. The following findings and recommendations are under serious consideration and discussions are being held regarding solutions to any unresolved problems.

RESPONSES AND FINDINGS

A. A Mental Health Crisis, Following the Call, the First 72 Hours Matter

FINDINGS

The Grand Jury findings:

F1. *There is a need for a Mobil Crisis Stabilization Team to reduce the strain on law enforcement and hospital emergency rooms, while providing vital care, support and referrals to individuals and families experiencing a mental health crisis.*

Response: The Board of Supervisors agrees with the finding. The County continues to explore options that will enhance services to those in crisis, including how to improve 'real-time' collaboration between providers.

F2. *The stigma of mental illness contributes to the use of hospital emergency rooms to access mental health services, resulting in crowded emergency rooms, delayed treatment, and long waits for all patients seeking medical or mental health care.*

Response: The Board of Supervisors disagrees wholly with the finding that crowded emergency rooms, delayed treatment and long waits for patients seeking medical or mental health care treatment are a result of a mental health stigma. The Board of Supervisors and Health and Human Services takes the opportunity to discuss, educate and promote awareness and treatment for mental illness in efforts to reduce stigma. Shasta County supports “Stand Against Stigma, Changing minds about mental illness,” “Brave Faces and Voices” and many other programs offered by Shasta County Health and Human Services. Thousands of Shasta County residents receive outpatient specialty mental health services from the Health and Human Services Agency each year. Additionally, there are many other factors that affect the number of users of emergency room services including, but not limited, uninsured or underinsured patients, access to urgent care centers, and general cost of medical care. The County is unaware of any verifiable data that stigma relating to mental health results in congestion of emergency rooms.

F3. *The public, in particular families who are experiencing a first-time mental health crisis, is often not aware of available services at the Shasta County Mental Health walk-in clinic, resulting in lack of early intervention and treatment.*

Response: The Board of Supervisors partially disagrees with the finding that families who are experiencing a first-time mental health crisis are often not aware of available services. The Board of Supervisors and Health and Human Services continues ongoing efforts to educate the public about mental health services available at numerous providers throughout the County, as well as additional mental health services offered by a variety of organizations and individual professionals currently operating in our community.

F4. *The Shasta County Mental Health walk-in clinic is not available 24 hours a day, 7 days a week, resulting in the need to access care through hospital emergency rooms.*

Response: The Board of Supervisors agrees with the finding. Shasta County is undertaking a project to enhance and expand opportunities for services outside normal business hours by creating a mental health resource center.

F6. *There are only 16 adult psychiatric beds in Shasta County and none available for children. This results in delayed treatment, long waits in emergency rooms, and separating patients from their support system. With the limited number of beds for adults and none for children, treatment time increases because of the time necessary for transporting patients outside Shasta County.*

Response: The Board of Supervisors agrees with the finding. The County continues its efforts to promote private enterprises to develop additional psychiatric beds, including opportunities for children. Currently, one such facility is under development in Tehama County, which is much closer than facilities we currently contract with.

RECOMMENDATIONS

The Grand Jury recommends:

R1. *The Grand Jury recommends that by December 31, 2016, the Board of Supervisors direct Shasta County Mental Health Services to develop a plan that provides a permanent Mobile Crisis Stabilization Team in partnership with law enforcement to address crisis situations in the field, utilizing new Mental Health Services Act (MHSA) funding.*

Response: The recommendation requires further analysis. The Board of Supervisors supports the idea of a Mobil Crisis Stabilization Team, however costs, funding and staffing must be analyzed and funding and staffing secured prior to creating such a team. The Board of Supervisors will direct staff to review opportunities for funding and staffing a Mobil Crisis Stabilization Team by November 30, 2016.

R2. *The Grand Jury recommends that by December 31, 2016, the Board of Supervisors adopts a plan with Shasta County Mental Health Services to establish a Mental Health Resource Center with expanded hours to provide and support and counseling services.*

Response: The recommendation has not yet been implemented but will be by June 30, 2017. Shasta County has been working with non-profit organizations to contract for mental health services and the creation of a resource center that will provide support and counseling services to both adults, children, and their families.

R3. *The Grand Jury recommends that by December 31, 2016, the Board of Supervisors directs Shasta County Mental Health Services to expand the hours of the Mental Health walk-in clinic, to include nights and weekends, until the proposed Mental Health Resource Center is open to the public.*

Response: The recommendation requires further analysis. The Board of Supervisors will direct staff to evaluate the costs to expand the hours of operation of the Mental Health walk-in clinic and review opportunities for funding by November 30, 2016.

The Honorable Gregory Gaul
Shasta County Superior Court
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Page 4

R4.*The Grand Jury recommends that by December 31, 2016, the Board of Supervisors directs Shasta County Mental Health Services to initiate an ongoing campaign to promote public awareness of current mental health services available to children and adults in Shasta County.*

Response: The recommendation has been implemented.

R6.*The Grand Jury recommends that by December 31, 2016, the Board of Supervisors adopts a plan with Shasta County Mental Health Services to work with Restpadd and other interested providers to locate additional facilities in Shasta County that will increase the number of inpatient psychiatric beds for adults.*

Response: The recommendation has been implemented.

This concludes the responses of the Shasta County Board of Supervisors to the FY 2015-2016 Grand Jury Report, The Mental Health Crisis, Following the Call, the First 72 Hours Matter.

Sincerely,

PAM GIACOMINI, Chairman
Board of Supervisors
County of Shasta

LGL:jd

Shasta County Grand Jury

A Mental Health Crisis, Following the Call The First 72 Hours Matter



[Image source: www.google.com]

SUMMARY

Access to mental health stabilization services for people in a mental health crisis is lacking in Shasta County. The Grand Jury found that there is a significant gap in care during a mental health crisis, particularly when the Shasta County Mental Health Services walk-in clinic is closed during nights and weekends. Mental illness does not discriminate, is not self-induced or self-caused, and can affect children, teens, adults, veterans, and senior citizens. One out of four people in Shasta County suffers from a mental health disorder.

There are various reasons why people suffering with mental health conditions may choose not to seek treatment. Shame and discrimination associated with mental health problems create a stigma which prevents some people from reaching out for the help they need, and may delay treatment.

Public awareness of issues facing the mentally ill in Shasta County is gaining momentum. A proposal has been approved by the Shasta County Board of Supervisors for a Mental Health Resource Center to be located in Redding that could provide after hours and weekend mental health services. This seems to be moving Shasta County in the right direction.

Presentations to the Shasta County community by national mental health advocates have helped improve awareness for the need to rapidly stabilize patients who are experiencing an acute crisis. Prompt intervention helps prevent local emergency room visits and reduces the need for incarceration. A Mobile Crisis Stabilization Team has shown to be one of the most effective approaches, and would provide an immediate on-site response for people in a mental health crisis. Also, additional Crisis Intervention Training (CIT) for law enforcement officers would improve their skills and help them recognize signs of a mental health emergency and respond appropriately.

This report discusses what happens within the first 72 hours after making a 911 call for help when a person is experiencing a mental health crisis in Shasta County.

BACKGROUND

The Grand Jury conducted an investigation of mental health services in Shasta County, focusing on the first 72 hours of a mental health crisis. The Grand Jury's guiding question was, "What happens if a person calls 911 for help when someone is harming themselves, threatening suicide, has overdosed, or is acting out with threatening or unusual behaviors?" Caring for people

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experiencing their first-time mental health crisis can be daunting and confusing. Friends or families may not know where to go, who to turn to for help, or what facilities and services are available. When a call is finally made to a mental health help line or doctor's office, and families are told to call 911, what happens?

METHODOLOGY

- Observed operations and interviewed staff of Shasta Area Safety Communications Agency (SHASCOM)
- Attended a National Alliance on Mental Illness (NAMI) sponsored public discussion with the Shasta County Sheriff as speaker
- Toured the Shasta County Jail and interviewed jail staff
- Toured the Tehama County Community Crisis Response Unit and interviewed staff
- Toured the Shasta County Juvenile Rehabilitation Facility
- Toured the Shasta County Mental Health Center and the co-located Residential Center
- Reviewed the National Academies Emergency Dispatch Protocol #25 covering psychiatric, abnormal behavior, and suicide attempts
- Reviewed California Department of Justice Bureau of Firearms website and Informational Bulletin Number 2012-BOF-02, New Mental Health Firearms Prohibition Reporting System
- Reviewed Proposition 63, the California Mental Health Services Act (MHSA)
- Reviewed California Health and Safety Code Sections 1797-1799.207
- Reviewed California Welfare and Institutions Code Sections 5150-5155
- Reviewed California Welfare and Institutions Code Sections 8100-8103
- Reviewed Shasta County Mental Health's Three-Year Program & Expenditure Plan for 2014/15, 2015/16, and 2016/17
- Reviewed Shasta County Mental Health informational websites
- Reviewed the December, 2015 Shasta County Crisis Services Activity Report
- Interviewed staff from the City of Redding Police Department
- Interviewed staff from the Shasta County Sheriff's Office
- Interviewed staff from Shasta Regional Medical Center
- Interviewed staff from Mercy Medical Center
- Interviewed staff from Shasta County Mental Health Services

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DISCUSSION

Following the Call

In this investigation, the Grand Jury began with the scenario of a person calling 911 when someone is experiencing a mental health crisis. A mental health crisis occurs when a person is expressing suicidal thoughts, deliberately harming themselves, experiencing a panic attack, or appears acutely psychotic. The Grand Jury wanted to know what happens in Shasta County within the first 72 hours of a mental health crisis. When a citizen calls 911 for mental health help, where does the call go?

Dialing 911 – Shasta Area Safety Communications (SHASCOM)

The 911 call starts at the Shasta Area Safety Communications (SHASCOM) dispatch center. Dispatchers talk to the caller and assess the situation based on the information provided. SHASCOM then hands off the call to the appropriate law enforcement agency, either the Shasta County Sheriff's Department or a city police department. Law enforcement is dispatched and emergency resources are sent if medical aid is indicated. Medical personnel when responding, wait at a safe location nearby until law enforcement has secured the scene.

In 2015, SHASCOM dispatchers handled 442,308 emergency and non-emergency calls resulting in 196,968 incidents that required the dispatch of law enforcement, fire, or other emergency personnel. According to SHASCOM administration officials, the current computer-aided dispatch system is unable to track the actual number of mental health emergency calls.

Law Enforcement Responds to Call Dispatched by SHASCOM

All calls made to 911 for mental health emergencies are dispatched to a law enforcement officer who is provided with the initial information and the calling party's phone number. The assigned officer(s) assess the nature of the mental health crisis, secure the scene, and allow any necessary emergency medical personnel to then approach. A person in crisis can agree to voluntarily receive treatment and be transported by ambulance (if dispatched) or by law enforcement to a hospital or the Shasta County Mental Health Clinic (during business hours). If the law enforcement officer determines that the person in crisis is a danger to themselves or others, or is gravely disabled, then California Welfare and Institution Code 5150 applies.

California Welfare and Institution Code Section 5150 (a) provides: *"When a person, as a result of a mental health disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, professional person in charge of a facility designated by the county for evaluation and treatment, member of the attending staff, as defined by regulation, of a facility designated by the county for evaluation and treatment, designated members of a mobile crisis team, or professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody for a period of up to 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 Health Care Services."*

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California Welfare and Institution Code Section "5150" allows law enforcement to place a person under a 72 hour **involuntary** hold if they meet the definition of a danger to self or others, or are gravely disabled. These individuals will be transported to one of the local hospital emergency rooms by law enforcement officers for evaluation and treatment, as needed.

Crisis Intervention Training (CIT) for law enforcement officers provides for improved officer safety, improved recognition of a wide variety of mental health disabilities and disorders, and teaches de-escalation techniques. This training empowers law enforcement officers so they can help stabilize a person in crisis, often preventing the need for emergency room visits and reducing the amount of time a mental health call diverts law enforcement officers from being available to respond to other emergency calls for service. The benefits of CIT in many situations are that an officer or emergency personnel can de-escalate the situation and refer the person to mental health services for follow-up. Law enforcement officers receive CIT during their initial academy training. Between 50% and 60% of the Sheriff's Office and the Redding Police Department officers have received additional CIT. The representatives from two law enforcement agencies the Grand Jury interviewed stated that additional CIT would be beneficial to all officers.

In the Hospital Emergency Room

When mental health patients arrive at one of the three local hospitals, Mayers Memorial Hospital in Fall River Mills, or either Shasta Regional Medical Center or Mercy Medical Center in Redding, they are initially assessed, treated and medically stabilized in the emergency room. Mental health patients with more serious medical needs will be transferred out of the emergency room to an acute care room in the hospital. Mental health patients who have committed a crime will first be medically cleared by emergency room staff and then transported by law enforcement to the Shasta County Jail where they are held and treated. Mental health patients who are voluntarily transported to the hospital can be released by medical personnel after an evaluation is completed by an emergency room physician and medically cleared.

Emergency room physicians may consult with an out-of- county contract psychiatrist, via an internet-based video conference referred to as "Tele-Psychiatrist." Through consultation with the treating physician, the psychiatrist determines if there is a need for psychiatric medications as part of the emergency room treatment. Tele-psychiatrists are utilized because there are few local psychiatrists in Shasta County. This alternative offers local emergency room patients with psychiatric stabilization until a mental health evaluation is completed.

A "5150 hold" authorized by a peace officer places the mental health patient on a 72 hour involuntary mental health observation hold. In Shasta County, this can only be cleared by licensed staff of Shasta County Mental Health. Mental health patients brought to the emergency room at the direction of law enforcement, but who are not treated or released, or not subjected to a "5150 hold", are placed under a different type of hold, called a "1799 hold". This is a 24 hour hold issued by an emergency room physician as authorized by the provisions of Health and Safety Code Section 1799. The hold remains in place until a County Mental Health evaluator

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arrives and determines if the patient meets "5150" criteria or can be released. If the patient meets the "5150" definition, the 24 hour hold is changed to a 72 hour hold.

Hospitals Consult with Shasta County Mental Health Services

The procedures for a mental health patient's medical clearance are identical for both children and adults. This includes the following general protocol: physical assessment, laboratory tests, and completion of the medical record for the patient's hospital visit. The medical clearance must be completed prior to a Shasta County Adult Mental Health evaluation. In addition, there is a Children's Mental Health branch that evaluates patients under the age of 18.

Once the medical clearance is completed, the hospital will fax a request for evaluation to Shasta County Mental Health Services. When an evaluator is available, they will travel to the emergency room. Licensed mental health staff will complete a patient "face to face" assessment and determine what level of care is needed. Patients under an involuntary "1799" or a "5150" hold will be evaluated and the hold will either be confirmed for additional treatment in a psychiatric hospital, or the patient will be released.

After hours and on weekends, the hospital still sends the fax to the Shasta County Mental Health Service office where staff addresses the request the following morning. This can result in long waits for patients in the emergency room. The average response from a 911 call to completion of the patient evaluation by mental health staff is six to eight hours, but is longer for patients admitted on nights and weekends. When the Grand Jury toured the Shasta County Mental Health Services office, there were nine active cases on the status board awaiting evaluation. During interviews with Shasta Regional Medical Center and Mercy Medical Center staff, the Grand Jury learned that hospital emergency rooms are often crowded with mental health patients, causing long waits for all emergency room patients. Representatives from both hospitals expressed frustration with the current system.

Shasta County Mental Health Services conducts between 120 to 160 in-hospital evaluations per month. Of these evaluations, 10 to 20 are for patients under the age of 18. After initial evaluation by a mental health evaluator, 60% to 65% of the patients are discharged and provided a follow-up plan for local treatment, if necessary.

Patients who are released may be provided with follow-up treatment by Shasta County Mental Health Services, which includes providing the patients a list of locally available resources. These patients often have appointments scheduled for them by county staff or they are given referrals to other service providers. Patients can also schedule their own appointment with the Shasta County Mental Health Clinic at 2650 Breslauer Way in Redding.

A pilot program recently introduced by Shasta County Mental Health Services co-locates mental health evaluators in two of the three hospital emergency rooms Monday through Friday, 8:00 a.m. to 5:00 p.m., potentially resulting in shorter patient wait times during those hours. However, this program has not improved wait times for nights and weekends. Expanding this program could expedite the patient assessment process necessary for either releasing a patient under a psychiatric hold, or in obtaining placement in a psychiatric hospital.

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Shasta County's three acute hospitals, Mayers Memorial Hospital, Shasta Regional Medical Center and Mercy Medical Center do not have licensed psychiatric beds. All mental health patients who do not require hospitalization for medical issues, but require additional treatment in a psychiatric hospital, are held in the emergency room until transported to a psychiatric facility. Administrative staff from both local hospitals indicated and Shasta County Mental Health Services confirmed that during this extended stay, no actual counseling or mental health services are provided to patients.

County Mental Health Services Arranges Psychiatric Hospitalization

Treatment and placement in a psychiatric hospital, if deemed necessary, may be delayed until a patient's information packet containing laboratory reports, patient history, and determination of insurance is completed. In addition, long delays result from the lack of available licensed psychiatric beds for patients who need continued inpatient mental health treatment.

Mental Health evaluators seeking placement for Shasta County patients who require treatment in an in-patient psychiatric facility face serious challenges. California's licensed psychiatric hospitals with available beds are in short supply. Also, they will accept or refuse patients depending on: the level of care needed, the patient's history, availability of medical insurance, and even a patient's size and weight. There are 16 licensed adult psychiatric beds available in Shasta County, located at Restpadd on Eureka Way. Restpadd does not have psychiatric beds for children. The closest inpatient hospital for children and adolescents is in Sacramento, which results in additional hardship and trauma for the patient.

The lack of readily available placement options means that a patient could actually stay in the local emergency room for weeks while waiting for a bed to become available at a psychiatric hospital. According to local hospital representatives, a Shasta County patient was recently boarded in the emergency room for 45 days awaiting an appropriate psychiatric inpatient bed. An available bed was eventually found and the patient was transported to San Diego. This long wait without proper psychiatric care is detrimental to the patient's recovery.

Alternate Solutions

During this investigation, the Grand Jury found that some counties utilize a Mobile Crisis Stabilization Team. There are successful models Shasta County could use to develop a local team. An effective model might be composed of a law enforcement officer paired with a mental health staff member who can jointly respond to calls in the community. Trained staff could conduct an immediate mental health assessment and provide crisis resolution, family education, and other relevant information or mental health service referrals. The ability to provide and recommend services to patients where they live or in the field could reduce time spent by law enforcement in transferring patients to hospitals. This could also reduce inpatient psychiatric hospitalization and provide better outcomes in the least restrictive manner for individuals with mental health conditions. Additionally, it would reduce associated trauma to family and caregivers.

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On January 1, 2005, Proposition 63, also known as the Mental Health Services Act (MHSA), which proposed a 1% tax on adjusted annual income over one million dollars became law. This stream of funding is dedicated to transforming the public mental health system and seeks to reduce the long-term negative impact from untreated serious mental illness. Shasta County receives additional annual funding as a result of the MHSA.

Innovation is a project component under MHSA. Innovation projects must be novel, creative, and/or ingenious mental health practices or approaches and may be used for increasing the quality of services including better outcomes, promoting inter-agency collaboration and increasing access to services. This funding was created for the purpose of developing new mental health practices, testing and evaluating the model, and sharing the results with the statewide mental health system. This funding cannot be used for inpatient beds. However, creating a Mobile Crisis Intervention Team in Shasta County may qualify as an innovation project, as defined in the MHSA. Furthermore, creating a mobile crisis unit would not require a new building and new funds could be available through MHSA.

Currently, Shasta County offers mental health services at the Mental Health Walk-In Clinic at 2650 Breslauer Way, Monday through Friday, 8:00 a.m. through 5:00 p.m. Outpatient services for children and adults include counseling assessment, case management, medication, urgent care, and crisis services. Referrals to a psychiatrist can be made for privately insured patients; however, because of the lack of psychiatrists, new patients typically wait up to 90 days for an appointment. Preventative care, education about the early signs of mental illness, and intervention are keys to successful treatment. Interviews with mental health professionals by the Grand Jury indicate that the stigma attached to mental illness may cause many emergency room visits to be by patients who are seeking mental health services, preferring to use the emergency room rather than the walk-in Mental Health Clinic. Eliminating the stigma surrounding mental illness, which may result in delayed care, is critical for Shasta County to be successful in the treatment of the mentally ill.

Shasta County citizens concerned about losing their right to own a firearm by seeking treatment for mental health issues should understand that preventative treatment does not trigger notification to the Department of Justice. According to Welfare and Institutions Code Sections 8100-8103, it is only at the point when a person is determined to be a danger to themselves or others, or gravely disabled, or admitted to a facility for inpatient psychiatric treatment that notification must be provided to the Department of Justice.

FINDINGS

- F1. There is a need for a Mobile Crisis Stabilization Team to reduce the strain on law enforcement and hospital emergency rooms, while providing vital care, support, and referrals to individuals and families experiencing a mental health crisis.
- F2. The stigma of mental illness contributes to the use of hospital emergency rooms to access mental health services, resulting in crowded emergency rooms, delayed treatment, and long waits for all patients seeking medical or mental health care.

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- F3. The public, in particular families who are experiencing a first-time mental health crisis, is often not aware of available services at the Shasta County Mental Health walk-in clinic, resulting in lack of early intervention and treatment.
- F4. The Shasta County Mental Health walk-in clinic is not available 24 hours a day, 7 days a week, resulting in the need to access care through hospital emergency rooms.
- F5. Law enforcement officers may or may not have received Crisis Intervention Training (CIT) beyond that received during their academy training. Continuing updated CIT education in the recognition of mental illness and de-escalation techniques could help prevent transporting patients to hospital emergency rooms or county jail.
- F6. There are only 16 adult psychiatric beds in Shasta County and none available for children. This results in delayed treatment, long waits in the emergency rooms, and separating patients from their support system. With the limited number of beds for adults and none for children, treatment time increases because of the time necessary for transporting patients outside Shasta County.

COMMENDATIONS

The Grand Jury commends Shasta County Mental Health Services for initiating its recent pilot program to co-locate county mental health evaluators in the two Redding hospital emergency departments. This program is intended to expedite the process of completing the mental health assessments and locating licensed psychiatric beds.

RECOMMENDATIONS

- R1. The Grand Jury recommends that by December 31, 2016, the Board of Supervisors direct Shasta County Mental Health Services to develop a plan that provides a permanent Mobile Crisis Stabilization Team in partnership with law enforcement to address crisis situations in the field, utilizing new Mental Health Services Act (MHSA) funding.
- R2. The Grand Jury recommends that by December 31, 2016, the Board of Supervisors adopts a plan with Shasta County Mental Health Services to establish a Mental Health Resource Center with expanded hours to provide support and counseling services.
- R3. The Grand Jury recommends that by December 31, 2016, the Board of Supervisors directs Shasta County Mental Health Services to expand the hours of the Mental Health walk-in clinic, to include nights and weekends, until the proposed Mental Health Resource Center is open to the public.
- R4. The Grand Jury recommends that by December 31, 2016, the Board of Supervisors directs Shasta County Mental Health Services to initiate an ongoing campaign to promote public awareness of current mental health services available to children and adults in Shasta County.
- R5. The Grand Jury recommends that by December 31, 2016, the City of Redding City Council, City of Anderson City Council, and the Shasta County Sheriff's Office each adopt

Shasta County Grand Jury

a departmental policy that requires Crisis Intervention Training, at a minimum of every two years, for all law enforcement officers, beginning.

- R6. The Grand Jury recommends that by December 31, 2016, the Board of Supervisors adopts a plan with Shasta County Mental Health Services to work with Restpadd and other interested providers to locate additional facilities in Shasta County that will increase the number of inpatient psychiatric beds for adults.
- R7. The Grand Jury recommends that by December 31, 2016, the Board of Supervisors adopts a plan with Shasta County Mental Health Services with detailed action and implementation timelines to establish a facility in Shasta County providing inpatient psychiatric beds for children.

REQUEST FOR RESPONSES

Pursuant to Penal Code Section 933.05, the following responses are required:

From the following governing bodies (within 90 days):

- Shasta County Board of Supervisors: **F1, F2, F3, F4, F6 and R1, R2, R3, R4, R6, R7**
- City of Redding City Council: **F5 and R5**
- City of Anderson City Council: **F5 and R5**

From the following elected county officer (within 90 days):

- Shasta County Sheriff-Coroner: **F5 and R5**

The Grand Jury recommends that all governing bodies place their responses to all Grand Jury Reports on their Regular Calendars for public discussion, not on their Consent Calendars.

INVITED RESPONSES

From the following individuals (within 60 days):

- Chief of Police, City of Redding: **F5 and R5**
- Chief of Police, City of Anderson: **F5 and R5**

When there is a perception of a conflict of interest involving a member of the Grand Jury, that member has been required to recuse from any aspect of the investigation involving such a conflict and from voting on the acceptance or rejection of that report. One member of the Grand Jury recused from this report.

Reports issued by the Grand Jury do not identify individuals interviewed. Penal Code Section 929 requires that reports of the Grand Jury not contain the name of any person or facts leading to the identity of any person who provides information to the Grand Jury.