

From: NAMI Southern Santa Barbara County; FamiliesAct; CLUE
To: Santa Barbara County Board of Supervisors
Subject: Gaps in the Mental Health Continuum of Care: Inpatient Care, Crisis Placements, Residential Treatment, and Housing
Date: July 20, 2016; revised August 19, 2016

In 2015-2016, the Santa Barbara County Board of Supervisors support for mental health services has yielded one million dollars for additional beds for short-term stabilization, a commitment of \$608,000 for a Laura's Law pilot program, and a nest egg of \$243,000 for future housing. We applaud the Supervisors' support.

We understand the Department of Behavioral Wellness will make a presentation on capital needs related to the continuum of care to the Board of Supervisors in August. We offer here our joint comment and recommendations.

Unfortunately, significant gaps in the continuum of care remain at all levels, contributing to mental health crises, homelessness, high ER utilization, and the criminalization of mental illness. Funding is inadequate at all levels of the continuum of care:

1. Santa Barbara County has 16 inpatient psychiatric hospital beds; whereas national standards indicate a county our size requires a minimum of 160 beds (see <http://www.psychiatrictimes.com/psychiatric-emergencies/dearth-psychiatric-beds>). This shortage of psychiatric hospital beds has resulted in the criminalization of mental illness, over-utilization of hospital ERs, and expensive out-of-county hospitalizations. We recommend as a first step the addition of 40 inpatient psychiatric beds.
2. Santa Barbara County has no IMD (Institution for Mental Disease) MHRC (Mental Health Rehabilitation Center) beds, the second category of inpatient care contracted for out-of-county. The cost of building such a facility is high (see [http://www.simivalleyacorn.com/news/2015-10-09/Health_\(and\)_Wellness/Mental_rehab_center_set_to_open_in_2016.html](http://www.simivalleyacorn.com/news/2015-10-09/Health_(and)_Wellness/Mental_rehab_center_set_to_open_in_2016.html))
3. The County has an inadequate number of crisis placements for persons requiring short-term stabilization. The dual purpose of California's SB82 crisis grants is to reduce unnecessary hospitalization AND to divert jail placements (see http://www.calhospital.org/sites/main/files/file-attachments/grant_background.pdf). Too many persons needing crisis stabilization continue to be incarcerated.
4. The county has a critical shortage of intensive residential treatment beds, resulting in utilization of out-of-county placements (e.g. Psynergy) for some persons, and inadequate care for others, contributing to a continuing cycle of mental health crisis.

5. The number of supported housing placements for persons with serious mental illness does not equal the need, perpetuating homelessness. Mental health services for persons in supportive housing are insufficient.

We support the Department of Behavioral Wellness Director's efforts to increase housing and treatment options in Santa Barbara County. We agree that "an ideal behavioral health system has access to housing and can meet programmatic needs at each level along the continuum of care." We observe inadequate funding results in inappropriate placements for persons at lower levels of care than needed, perpetuating the "revolving door" of homelessness, crisis, and criminalization. We lack data enabling us to track outcomes for persons with mental illness at various levels of the continuum of care, data that would support informed planning.

Recommendations:

1. Increase dollars from the general fund allocated to Intensive Residential Treatment beds, and Supported Housing placements.
2. Construct a chart detailing the number of inpatient beds (both within county and out-of-county), crisis beds, and beds for persons with mental illness at all levels of the housing continuum, including sources of funding, and indicating recently added beds.
3. A critical shortage of inpatient beds has resulted in overutilization of the jail and hospital emergency rooms for stabilization of mentally ill persons. (See https://www.washingtonpost.com/local/public-safety/mental-health-crisis-ensnares-inmates-judges-jailers-and-hospitals/2016/06/07/b5379c7c-2aa1-11e6-a3c4-0724e8e24f3f_story.html?tid=a_inl and <http://www.latimes.com/local/lanow/la-me-ln-mental-competency-cases-20160525-snap-story.html>). Do not consider the voluntary crisis residential beds as adequate substitutes for voluntary or involuntary inpatient beds. Do not reduce funding for out-of-county inpatient placements (psychiatric hospitalization and IMD/MHRC beds) unless, and until, a reduced need has been demonstrated.
4. We know of no data (either in-county or nationally) substantiating the claim that voluntary, short-term crisis placements, valuable as they are, have reversed the sum of psychiatric hospitalizations, emergency room utilizations, incarcerations, or impacted the cycle of mental health crisis. Recommendation: Track and report outcome data quarterly as defined in the county's SB 82 grant proposal (see attached). Track and report the number of psychiatric hospitalizations, emergency room utilizations, and incarcerations of persons with serious mental illness, as recommended by NAMI to the Board of Supervisors in December 2015. Continue to track

(on a quarterly basis) data on psychiatric hospitalizations, as defined by the Department of Behavioral Wellness (see attached).

5. Persons with mental illness placed in Supported Housing, Board and Cares, Room and Boards, Sober Living Homes and Shelters require an adequately intensive level of outpatient mental health services in order to succeed in such placements. Recommendations: Increase the number of mental health outreach contacts for persons living in such placements. Track the status of persons in Full Service Partnerships (FSPs) by utilizing the FSP-mandated Key Events Form and reporting results on a quarterly basis (see attached).
6. Persons deemed incompetent to stand trial (IST) continue to occupy beds at the Psychiatric Health Facility (PHF), with a greater number in isolation at the jail. As of June, a higher number of persons IST resided at the jail than at any other time in the past year. Recommendation: Examine our county's practice of criminalizing persons with serious mental illness for nuisance misdemeanors, and holding persons "incompetent to stand trial" in isolation in the jail. Develop a plan to divert these persons into treatment, instead.

SB 82 Triage and Facilities Grant Evaluation

ADMHS is in negotiation with UCSB to partner with us to evaluate the Triage and Facilities grants. The Triage grant does not require an extensive outcome evaluation, but the Crisis Stabilization Unit and Crisis Residential program will be evaluated in terms of client outcomes, client satisfaction and the success of peer integration. Below are the outcome metrics that were stated in the two grants.

Triage Grant Outcome Metrics

The funder requires that we report process, encounter and outcome evaluation on a regularly scheduled basis. Process data relates to our implementation of the program. Encounter information refers to data points such as unduplicated clients served, service contacts, and demographics of clients served. The outcomes we intend to report to the funder are the following:

Objective 1: Increase the number of triage responses to crises that may not meet the 5150 criteria by 75%, from approximately 247 to 432 per month, by the end of the first grant year (*ADMHS will develop mechanism to generate this data*).

Objective 2: Decrease psychiatric hospitalization admissions by 20% in year one 35% by year two and 50% by year 3 (*ADMHS generates this data*).

Objective 3: Decrease the average psychiatric hospitalization length of stays by 50%, from 9.2 days to 4.6 days, by the end of the first grant year. Particular attention will be paid to clients with psychotic diagnoses. Forty-three percent (43%) of clients admitted have a psychotic diagnosis, and 63% of those clients are hospitalized for more than 5 days compared to only 38.7% of clients with a depressive disorder diagnosis (*ADMHS generates this data*).

Objective 4: Decrease the number of hospital readmissions within 30 days by 50%, from 87 to 43.5, and between 31 days and 1 year by 50%, from 94 to 47, by the end of the first grant year (*ADMHS generates this data*).

Objective 5: Decrease the number of residents with mental health and/or substance abuse issues using the Emergency Room by 25%, from approximately 200 to 150, in the first year. The decrease will be 40% in year 2 and 50% by the end of year 3 (*Hospitals will report data to ADMHS*).

Objective 6: Reduce the time that clients wait in the Emergency Room before transferring to an inpatient setting or outpatient care. The average wait time for transfers to inpatient care will be reduced by 50%, from 22 hours to 11 hours by the end of the first grant year. Wait time for transfers to outpatient care will be reduced by 50%, from 15 to 7.5, by the end of the first grant year (*Hospitals will report data to ADMHS*).

Objective 7: Decrease the number of arrests residents with serious mental illness and/or co-occurring substance abuse issues by the end of the first grant year (*Law Enforcement will report this data to ADMH*).

Objective 8: Increase law enforcement partner satisfaction with response time to a crisis and successful intervention (*Law Enforcement will report this data to ADMH via satisfaction survey developed with UCSB*).

Objective 9: Decrease the wait time to first outpatient appointment after discharge from the hospital or jail by 30%, from an average of 15 days to 10.5 days, by the end of the first grant year. In subsequent grant years, the decrease in wait time will be 40% in year 2 and 50% in year 3. First contact with Triage Team will be on the day of discharge (*ADMHS generates this data*).

Facilities Grant Outcome Metrics

Similar to the Triage grant, the funder requires evaluation reporting on a regularly scheduled basis. Many of the metrics are the same as the Triage grant. In addition to the metrics listed below, UCSB will partner with ADMHS to conduct an evaluation of the Crisis Stabilization Unit and Crisis Residential program.

Objective 1: Reduce the time that medically stable clients wait in the Cottage Emergency Department before transferring to an inpatient setting or outpatient care, including crisis stabilization and respite care. The average wait time for transfers to inpatient care will be reduced by 50%, from 22 hours to 11 hours by the end of the first grant year. Wait time for transfers to outpatient care will be reduced by 50%, from 15 to 7.5, by the end of year 1 (*Hospitals will report data to ADMHS*).

Objective 2: Decrease psychiatric hospitalization admissions by 20% in year one, 35% by year two and 50% by year 3 (*ADMHS generates this data*).

Objective 3: Decrease the number of hospital readmissions within 30 days by 50%, from 88 to 44; and between 31 days and 1 year by 50%, from 94 to 47, by the end of year 1 (*ADMHS generates this data*).

Objective 4: Decrease the number of residents with mental health and/or substance abuse issues awaiting placement at the Emergency Department (for care beyond medical clearance) in South County by 50%, from approximately 900 to 450, in the first year. The decrease will be 75% in year 2 and 90% by the end of year 3 (*Hospitals will report data to ADMHS*).

Objective 5: Decrease the time that law enforcement spends waiting in the Emergency Department with residents with mental illness and/or co-occurring substance abuse issues by 20% in year 1, and 30% in year 2 (*Law Enforcement will report this data to ADMH*).

Objective 6: Increase law enforcement partner satisfaction with crisis response time, successful intervention and alternatives to restrictive care (*Law Enforcement will report this data to ADMH via satisfaction survey developed with UCSB*).

Objective 7: Clients receiving crisis services will be engaged in peer support and ongoing outpatient mental health services, including case management and placement, upon discharge or transfer from the three CHFFA Programs (*ADMHS generates this data*).

Objective 8: Client & family member perspective, experience in the program and satisfaction with services provided at Crisis Stabilization Unit and Crisis Residential Respite Care by peer and non-peer staff will be high, and remain high throughout the grant cycle (*ADMHS will report this data via satisfaction survey developed with UCSB*).

Objective 9: The Crisis Stabilization Unit in Santa Barbara will increase the number of daily available 24-hour beds from 0 to 10 upon implementation of the program in year 1 (*ADMHS generates this data*).

Objective 10: The Lompoc Mobile Crisis Support Team will hire a minimum of two mental health specialists and one peer advocate in year 1. The team will be supplied with two vehicles outfitted for rapid response to mental health emergencies (*ADMHS generates this data*).

Objective 11: Reduce that wait time for crisis response in Lompoc to 15 minutes upon implementation of the Lompoc Mobile Crisis Support Team (*ADMHS will develop a mechanism to generate this data*).

Objective 12: The Crisis Residential Respite Care in Santa Barbara will increase the number of residential beds from 0 to 8 upon implementation of the program in year 1 (*ADMHS generates this data*).

**Santa Barbara County Department of Behavioral Wellness
Inpatient Utilization Trends**

National and State Context¹

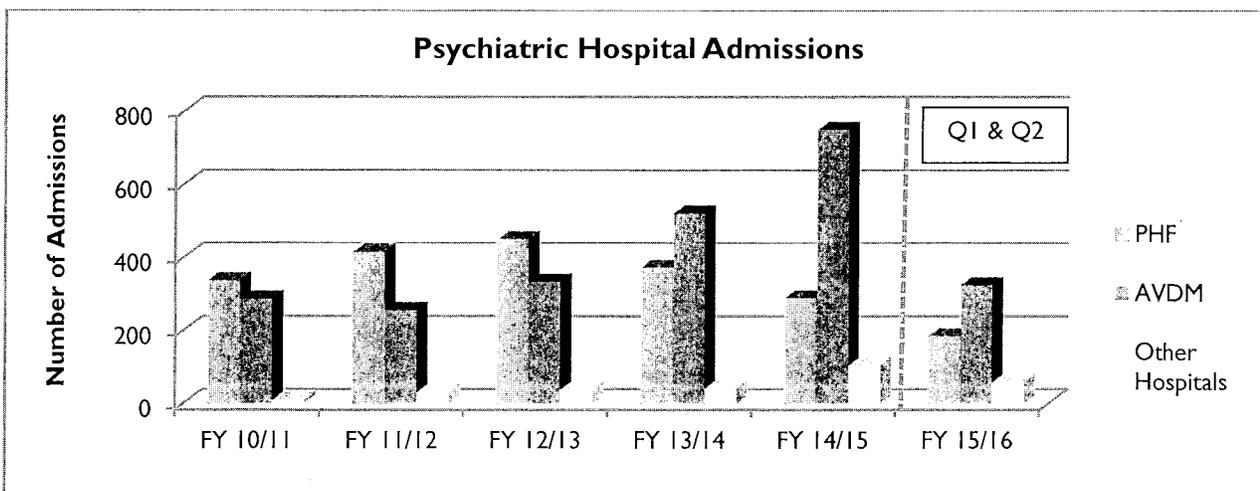
National bed rate = 1 bed per 4,953	CA beds are decreasing – 24% drop last 20 years; lost over 40 facilities	State average # beds = 17.43 per 100K
California’s bed rate = 1 bed per 5,572	CA population is increasing	SB County # beds = 8.26 beds per 100K
CA has fewer beds than rest of nation	Greater statewide need and increasing gap/ inability to meet need	SB County has fewer beds than rest of CA, and is less able to meet needs

Current Concerns

- Insufficient Number of Psychiatric Health Facility (PHF) beds**
- PHF is experiencing: a) longer lengths of stay and b) difficulty discharging, which results in increased use of out of county beds for admissions**

Contributing Factors:

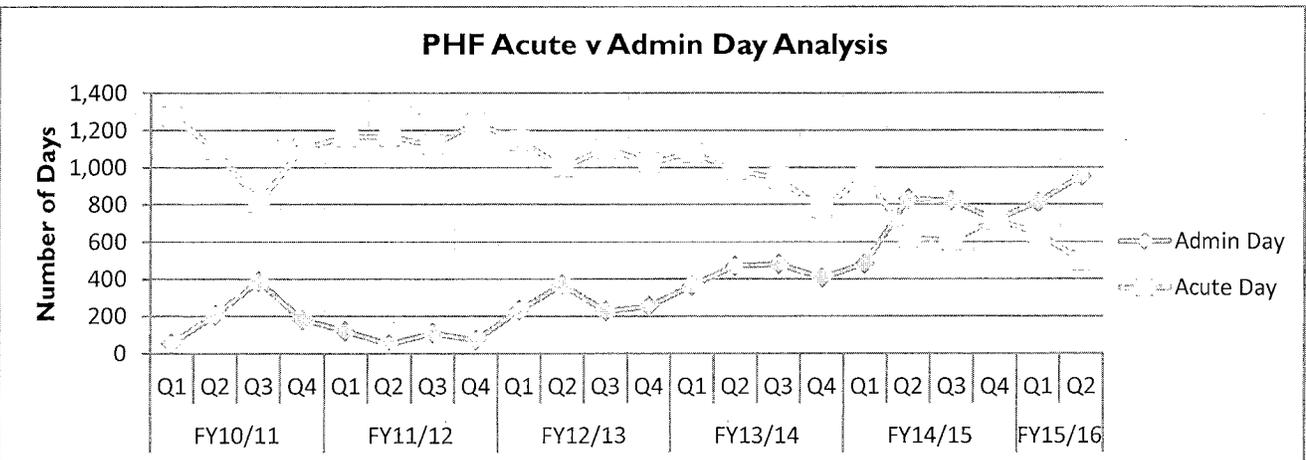
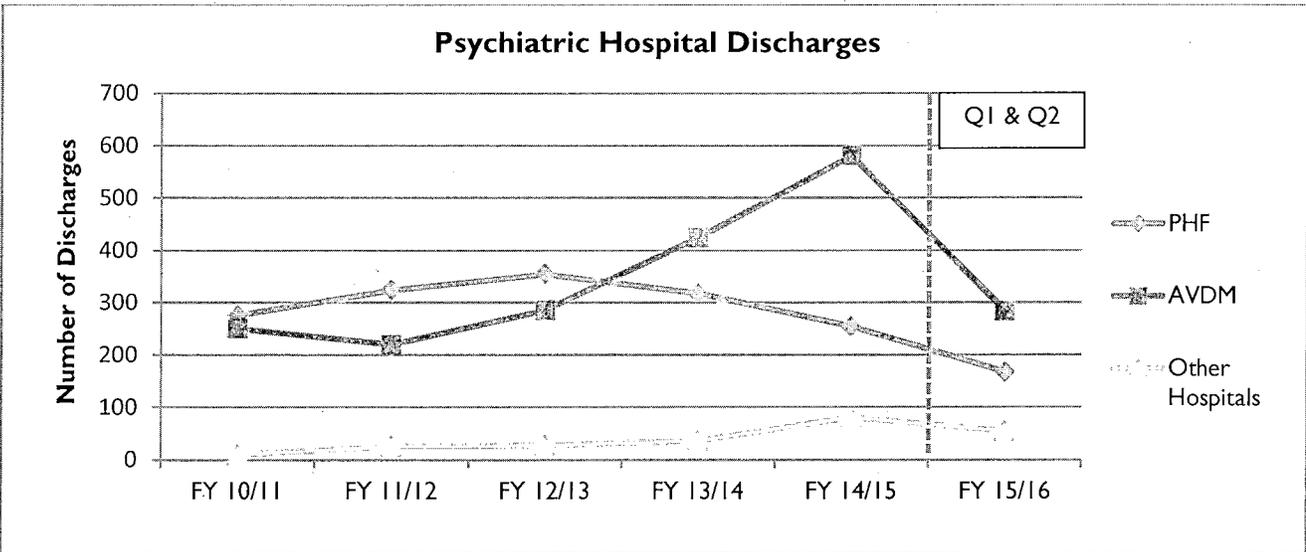
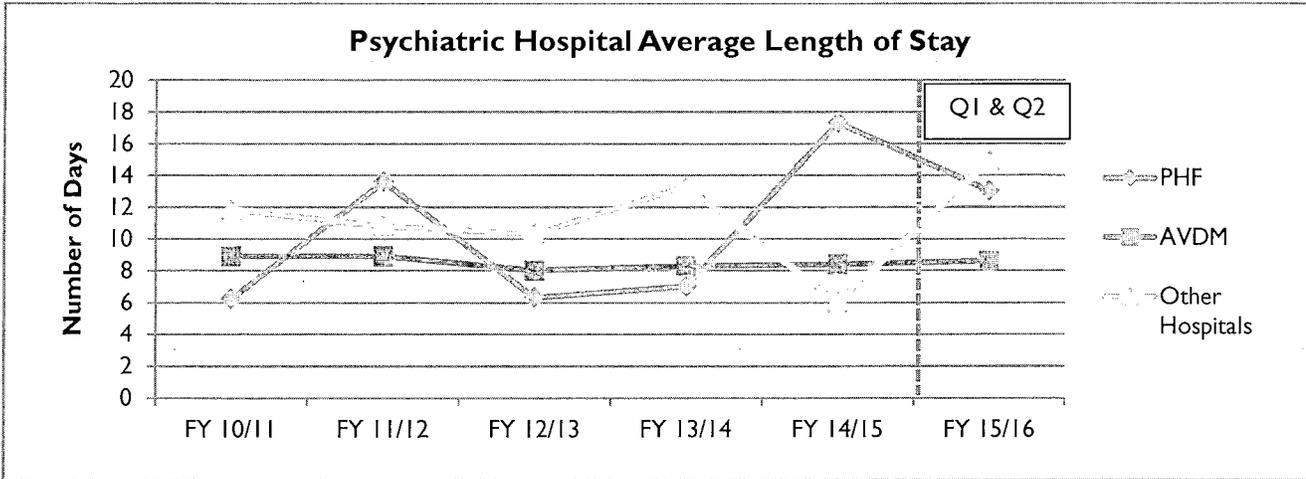
- Increasingly complex patients with more medical and substance abuse problems, coupled with an inadequate number of outpatient referral sites
- Older population; generally not accepted at Institutions for Mental Diseases and/or Crisis Residential Treatment centers
- Institutions for Mental Diseases and Skilled Nursing Facilities are increasingly more selective about types of admissions, and total number of such beds is thus decreasing
- Ongoing difficulties with 1370’s² and courts; non-acute Incompetent to Stand Trial clients in PHF prevents admission of new acute clients, who are then diverted to Aurora Vista Del Mar (AVDM)
- Crisis Residential Treatment and Alameda House referral process is restrictive
- Non-Dept. of Behavioral Wellness-related delays in temporary conservatorship processing creates longer PHF length of stays



¹ California Hospital Association Psychiatric Inpatient Bed Data <http://www.calhospital.org/PsychBedData>

² 1370s = Legal designation for people found to be Incompetent to Stand Trial due to a mental disorder

**Santa Barbara County Department of Behavioral Wellness
Inpatient Utilization Trends**



Note: Stricter adherence to Medi-Cal documentation guidelines over the last three years have led to more admin and less acute days. This change was most evident beginning Q2 14/15.

Santa Barbara County Department of Behavioral Wellness Inpatient Utilization Trends

Santa Barbara County System Improvements

Santa Barbara County is actively expanding the system and continuum of care in order to divert patients from hospitalization, decrease hospital admissions and decrease length of stay:

- Q2 14/15 Crisis Triage Teams Expanded County-Wide
- Q1 15/16 Crisis Residential South Opens
- Q2 15/16 Alameda House Opens
- Q3 FY 15/16 Crisis Stabilization Unit Opens

What is Needed

- Adequate number of in-county psychiatric beds, commensurate with the Santa Barbara County demand for acute psychiatric beds

FULL SERVICE PARTNERSHIP
Adult Key Event Tracking Form
FOR AGES 26-59 YEARS

PARTNERSHIP INFORMATION

County	<input type="text"/>	*
CSI County Client Number (CCN)	<input type="text"/>	
County Partner ID (optional)	<input type="text"/>	
Partner's First Name	<input type="text"/>	*
Partner's Last Name	<input type="text"/>	*
Date Completed (mm/dd/yyyy)	<input type="text"/>	*
Partner's Date of Birth (mm/dd/yyyy)	<input type="text"/>	*

CHANGE IN ADMINISTRATIVE INFORMATION (Skip this section if there are no changes)

PARTNERSHIP STATUS	
Date of Provider Number Change (mm/dd/yyyy): / NPI	<input type="text"/>
NEW Provider Number: / NPI	<input type="text"/>
Date of Full Service Partnership Program ID Change (mm/dd/yyyy):	<input type="text"/>
NEW Full Service Partnership Program ID:	<input type="text"/>
Date of Partnership Service Coordinator ID Change (mm/dd/yyyy):	<input type="text"/>
NEW Partnership Service Coordinator ID:	<input type="text"/>

CHANGE IN ADMINISTRATIVE INFORMATION (Skip this section if there are no changes) (Continued)

Date of Partnership Status Change (mm/dd/yyyy):

Indicate NEW partnership status:

- Discontinuation / Interruption of Full Service Partnership and / or community services / program (indicate reason below)
- Reestablishment of Full Service Partnership and / or community services / program

If there is a DISCONTINUATION / INTERRUPTION of Full Service Partnership and / or community services / program, indicate the reason (mark one):

- Target population criteria are not met.
- Partner decided to discontinue Full Service Partnership participation after partnership established.
- Partner moved to another county / service area.
- After repeated attempts to contact partner, s/he cannot be located.
- Community services / program interrupted – Partner's circumstances reflect a need for residential / institutional mental health services at this time [such as an Institution for Mental Disease (IMD), Mental Health Rehabilitation Center (MHRC), State Hospital].
- Community services / program interrupted – Partner will be serving JAIL sentence.
- Community services / program interrupted – Partner will be serving PRISON sentence.
- Partner has successfully met his / her goals such that discontinuation of Full Service Partnership is appropriate.
- Partner is deceased.

PROGRAM INFORMATION

Program Name	Date of Program Change (mm/dd/yyyy)	Currently Involved?
AB2034	<input type="text"/>	<input type="radio"/> Now enrolled in the AB2034 Program <input type="radio"/> No longer participating in the AB2034 Program
Governor's Homeless Initiative (GHI)	<input type="text"/>	<input type="radio"/> Now enrolled in the GHI Program <input type="radio"/> No longer participating in the GHI Program
MHSA Housing Program	<input type="text"/>	<input type="radio"/> Now enrolled in the MHSA Housing Program <input type="radio"/> No longer participating in the MHSA Housing Program

RESIDENTIAL INFORMATION - includes hospitalization and incarceration (Skip this section if there are no changes)

Date of Residential Status Change (mm/dd/yyyy):

SETTING

Indicate the new residential status (mark one):

GENERAL LIVING ARRANGEMENT

In an apartment or house alone / with spouse / partner / minor children / other dependents / roommate – must hold lease or share in rent / mortgage

With one or both biological / adoptive parents

With adult family member(s) other than parents

Single Room Occupancy (must hold lease)

SHELTER / HOMELESS

Emergency Shelter / Temporary Housing (includes people living with friends but paying no rent)

Homeless (includes people living in their cars)

SUPERVISED PLACEMENT

Unlicensed but supervised individual placement (includes paid caretakers, personal care attendants)

Assisted Living Facility

Unlicensed but supervised congregate placement (includes group living homes, sober living homes)

Licensed Community Care Facility (Board and Care)

HOSPITAL

Acute Medical Hospital

Acute Psychiatric Hospital / Psychiatric Health Facility (PHF)

State Psychiatric Hospital

RESIDENTIAL PROGRAM

Licensed Residential Treatment (includes crisis, short-term, long-term, substance abuse, dual diagnosis residential programs)

Skilled Nursing Facility (physical)

Skilled Nursing Facility (psychiatric)

Long-Term Institutional Care [Institution for Mental Disease (IMD), Mental Health Rehabilitation Center (MHRC)]

JUSTICE PLACEMENT

Jail

OTHER

Other

Unknown

EDUCATION (Skip this section if there are no changes)

GRADE LEVEL INFORMATION

Date of Grade Level Completion (mm/dd/yyyy):

Level of education completed:

- No High School Diploma / No GED
- GED Coursework
- High School Diploma / GED
- Some College / Some Technical or Vocational Training
- Associate's Degree (e.g., A.A., A.S.) / Technical or Vocational Degree
- Bachelor's Degree (e.g., B.A., B.S.)
- Master's Degree (e.g., M.A., M.S.)
- Doctoral Degree (e.g., M.D., Ph.D.)

EDUCATIONAL SETTING INFORMATION

Date of Educational Setting Change (mm/dd/yyyy):

If there are any educational setting changes, indicate ALL new and ongoing statuses including those previously reported.

	Setting
Not in school of any kind	<input type="checkbox"/>
High School / Adult Education	<input type="checkbox"/>
Technical / Vocational School	<input type="checkbox"/>
Community College / 4 year College	<input type="checkbox"/>
Graduate School	<input type="checkbox"/>
Other	<input type="checkbox"/>

If stopping school, did the partner complete a class and/or program? Yes No

Does one of the partner's current recovery goals include any kind of education at this time? Yes No

EMPLOYMENT (Skip this section if there are no changes)

Date of Employment Change (mm/dd/yyyy):

CURRENT EMPLOYMENT

If there are any changes to the partner's employment, indicate ALL new and ongoing statuses including those previously reported.

**AVERAGE
HOURS per
WEEK**

**AVERAGE
HOURLY WAGE**

Competitive Employment:

Paid employment in the community in a position that is also open to individuals without a disability.

\$

Supported Employment:

Competitive Employment (see above) with ongoing on-site or off-site job-related support services provided.

\$

Transitional Employment / Enclave:

Paid jobs in the community that are 1) open only to individuals with a disability AND 2) are either time-limited for the purpose of moving to a more permanent job OR are part of a group of disabled individuals who are working as a team in the midst of teams of non-disabled individuals who are performing the same work.

\$

Paid In-House Work (Sheltered Workshop / Work Experience / Agency-Owned Business):

Paid jobs open only to program participants with a disability. A *Sheltered Workshop* usually offers sub-minimum wage work in a simulated environment. A *Work Experience (Adjustment) Program* within an agency provides exposure to the standard expectations and advantages of employment. An *Agency-Owned Business* serves customers outside the agency and provides realistic work experiences and can be located at the program site or in the community.

\$

Non-paid (Volunteer) Work Experience:

Non-paid (volunteer) jobs in an agency or volunteer work in the community that provides exposure to the standard expectations of employment.

Other Gainful / Employment Activity:

Any informal employment activity that increases the partner's income (e.g., recycling, gardening, babysitting) OR participation in formal structured classes and / or workshops providing instruction on issues pertinent to getting a job. (Does NOT include such activities as panhandling or illegal activities such as prostitution.)

\$

The partner is not employed at this time.

Does one of the partner's current recovery goals include any kind of employment at this time?

Yes No

LEGAL ISSUES / DESIGNATIONS (Skip this section if there are no changes)

ARREST INFORMATION

Date Partner Arrested (mm/dd/yyyy):

PROBATION INFORMATION

Date of Probation Status Change (mm/dd/yyyy):

Indicate new probation status:

- Removed from Probation
- Placed on Probation

CONSERVATORSHIP INFORMATION

Date of Conservatorship Status Change (mm/dd/yyyy):

Indicate new conservatorship status:

- Removed from conservatorship
- Placed on conservatorship

PAYEE INFORMATION

Date of Payee Status Change (mm/dd/yyyy):

Indicate new payee status:

- Removed from payee status
- Placed on payee status

EMERGENCY INTERVENTION (Skip this section if there are no changes)

Date of Emergency Intervention (mm/dd/yyyy):

Indicate the type of emergency intervention: (e.g., emergency room visit, crisis stabilization unit)

- Physical Health Related
- Mental Health / Substance Abuse Related

COUNTY USE QUESTIONS (Skip this section if there are no changes)

COUNTY USE QUESTIONS

DATE of CHANGE
(mm/dd/yyyy)

NEW VALUE

County Use Field # 1

County Use Field # 2

County Use Field # 3

FULL SERVICE PARTNERSHIP
 Adult Quarterly Assessment Form
 FOR AGES 26-59 YEARS

ADULT 3M
5/1/07

PARTNERSHIP INFORMATION

County	<input type="text"/>	*
CSI County Client Number (CCN)	<input type="text"/>	
County Partner ID (optional)	<input type="text"/>	
Partner's First Name	<input type="text"/>	*
Partner's Last Name	<input type="text"/>	*
Date Completed (mm/dd/yyyy)	<input type="text"/>	*
Partner's Date of Birth (mm/dd/yyyy)	<input type="text"/>	*

SOURCES OF FINANCIAL SUPPORT

Indicate all the sources of financial support used to meet the needs of the partner:	CURRENTLY (mark all that apply)
Partner's Wages	<input type="checkbox"/>
Partner's Spouse / Significant Other's Wages	<input type="checkbox"/>
Savings	<input type="checkbox"/>
Other Family Member / Friend	<input type="checkbox"/>
Retirement / Social Security Income	<input type="checkbox"/>
Veteran's Assistance Benefits	<input type="checkbox"/>
Loan / Credit	<input type="checkbox"/>
Housing Subsidy	<input type="checkbox"/>
General Relief / General Assistance	<input type="checkbox"/>
Food Stamps	<input type="checkbox"/>
Temporary Assistance for Needy Families (TANF)	<input type="checkbox"/>
Supplemental Security Income / State Supplementary Payment (SSI / SSP) Program	<input type="checkbox"/>
Social Security Disability Insurance (SSDI)	<input type="checkbox"/>
State Disability Insurance (SDI)	<input type="checkbox"/>
American Indian Tribal Benefits (e.g., per capita, revenue sharing, trust disbursements)	<input type="checkbox"/>
Other	<input type="checkbox"/>
No Financial Support	<input type="checkbox"/>

LEGAL ISSUES / DESIGNATIONS

CUSTODY INFORMATION

Indicate the total number of children the partner has who are CURRENTLY:

Placed on W & I Code 300 Status:
(Dependent of the court)

Placed in Foster Care:

Legally Reunified with partner:

Adopted out:

HEALTH STATUS

Does the partner have a primary care physician CURRENTLY? Yes No

SUBSTANCE ABUSE

In the opinion of the partnership service coordinator, does the partner CURRENTLY have an active co-occurring mental illness and substance use problem? Yes No

Is the partner CURRENTLY receiving substance abuse services? Yes No

COUNTY USE QUESTIONS

COUNTY USE QUESTIONS

NEW VALUE

County Use Field # 1

County Use Field # 2

County Use Field # 3

NAMI supports the Department of Behavioral Wellness's proposal to add residential beds at all levels of the mental health continuum of care. We applaud the department's focus on residential care and housing. We know beds are lacking at all levels.

We in NAMI know that persons in mental health crisis languish on the streets, are repeatedly jailed, and are over-running Cottage, Marion and the Lompoc hospitals on 72 hour holds, due to a critical shortage of acute, inpatient beds. This category of bed shortage, by no means unique to our County, has been referred to as "a bed shell game with life-and-death implications." We know that persons cycle through the PHF and Vista del Mar, with insufficient time to stabilize, due to the shortage of beds.

Only when we have sufficient inpatient capacity to adequately stabilize persons with the most severe illness can we begin to break the revolving door cycle of homelessness, crisis and incarceration our county's high utilizers experience. We know that voluntary crisis placements, while invaluable for some, simply do not work for many seriously ill persons who refuse treatment.

National studies of psychiatric bed need specifies 40 to 60 beds to adequately serve a population of 100,000. We have 16 beds in Santa Barbara County serving a population of well over 400,000. An adequate number of beds would be at least 160. While the prospect of a "cost neutral" proposal to replace 10 out-of-county placements with the same number of beds in-county is appealing from a financial standpoint, it does nothing to address the severe shortage of psychiatric beds. As an initial goal, we recommend the addition of 40 in-county psychiatric beds.

Secondly, this month we in NAMI are restating our December recommendation for quarterly reports on the number of jail days, and the number of ER utilization days by persons with mental illness – in addition to the number of psychiatric bed days. Our conversations with the Sheriff's Department and Cottage ER indicate this is doable. Only by tracking these three categories can we grasp the impact of untreated mental illness on our community, and the success of our ongoing efforts to reduce crisis.

Thank you.