HUMAN INVESTMENT INITIATIVE

MENTAL HEALTH CLUSTER

MAY 1, 2009

First Year's Observations, Conclusions & Recommendations

The mental health care system in California is tragically broken. When our 10-year old has needed psychiatric hospitalization, we've had to go to Los Angeles or to the Bay Area (the closest child/teen units), where she has sometimes been on units with much older adolescents. Fresno County recently closed the adult mental health crisis unit, and we are worried that the already "streamlined" children's unit may be next...

Rev. Bet Hannon, Fresno

Reprinted by Permission

Executive Summary

"We have met the solution and it is us." - Pogo Paraphrase

Overview

As demonstrated by the success of the Regional Jobs Initiative, our community is in the midst of a fundamental transformation. We are shifting from the expectation that government and single interest advocacy is the answer to our problems to a recognition that solutions will require new approaches, new partnerships and every individual stepping up to take responsibility for the success and well being of all residents. We, not government, are responsible for creating the world we want. In that spirit, the Human Investment Initiative ("HII") was launched in 2007 to address the destructive force of poverty in our neighborhoods and the lack of alignment of our community resources behind shared strategies. One HII task force of private citizens, the Mental Health Cluster ("MHC"), was formed in February 2008 to evaluate mental health services in Central California. At the outset of the effort, the members of the Mental Health Cluster agreed to act in accordance with the Community Values included at the end of this report. These will be important as we take the next steps.

This report summarizes our observations and conclusions.

Observations

Mental health services in Central California are inadequate, seriously so in many areas. It is estimated that two-thirds of seriously mentally ill individuals do not obtain care primarily because of a lack of availability of services but also because they lack either the means or the awareness of treatment alternatives.

There is a critical shortage of mental health professionals, facilities and programs. Mental health professionals cannot be attracted or retained in the region for a number of reasons:

- Inadequate strategy and leadership
- Inadequate number of training facilities
- Inadequate compensation
- Better pay and benefits in prison system and other regions
- Inadequate support programs and facilities
- Low recruitment of mental health workers
- Low retention of mental health workers

In addition to the shortage of mental health professionals, the region faces other critical deficiencies:

- Shortage of support services/programs to assist mental health professionals
- Shortage of public and private funding of mental health services in the Central Valley, a condition that is unlikely to change in the foreseeable future
- Lack of prevention programs; jails rather than early intervention
- Shortage of inpatient services, particularly in child and adolescent services
- Shortage of transitional, supportive housing facilities and support programs of all types
- Lack of coordination of services around a central strategy
- Comparatively large uninsured/under-insured population

Unfortunate outcomes from this situation include the following:

- Chronic unemployment and absenteeism
- More crime
- Excess use for emergency rooms instead of having a regular health care provider
- Homelessness
- Discouraging environment for the health care professionals

Conclusions

The MHC has identified a number of gaps in mental health services in the Central Valley. Such shortages are typical of most communities in the United States but they are more acute in the Central Valley.

- Lack of coordination of services around a central strategy
- Shortage of mental health professionals
- Shortage of support services/programs to assist mental health professionals
- Emphasis on treatment rather than prevention, jails rather than early intervention
- Shortage of inpatient services, particularly in child and adolescent services
- Shortage of step down, transitional, supportive housing facilities and support programs of all types
- Chronic under-funding of mental health services in Central Valley
- Incomplete public health prevention strategy
- The government funding shortfall and lack of insurance coverage are unlikely to improve
- Services are unacceptably inadequate
- The status quo is unacceptable
- The region must take responsibility for developing a plan of correction
- The MHC proposes four initiatives:
    a) The convening of all the critical mental health service groups, government, community benefit organizations (not for profits), mental health professionals, and citizens committed to improving the delivery of services to develop a plan of improvement of mental health services in the region
    b) The Behavioral Health Sciences Center
    c) Supportive Housing
    d) Day Treatment Center for Seriously Mentally Ill

Mental Health Cluster
Observations and Conclusions after Year One
February 2008-February 2009

Introduction

In 2007, a number of community partners issued the Human Investment Initiative ("HII"). The HII is a multi-sector effort to address concentrated poverty beginning in the urban core of Fresno. New approaches to mental health issues are central to this effort. As part of the HII, the Mental Health Cluster ("MHC") first convened in February of 2008 bringing together a diverse group of citizens to examine this question:

Is there a way to improve mental health services in our four county (Fresno, Kings, Tulare and Madera) region?

Our answer is "Yes." We believe there is a better way to coordinate mental health services in the region but it will require systemic change. We further believe that those involved in the delivery of these services are best able to identify deficiencies and propose solutions. What is missing is the right model for such explorations and the leadership to convene all the parties. The region needs a method to look at all services and evaluate their effectiveness, to develop programs to fill in the gaps and a governance structure committed to evidence based monitoring, plan correction and leadership and authority to implement change. Until and unless a more qualified body convenes and takes up this cause, the MHC will continue to explore ways to expand the community conversation on mental health services and ways to implement sustainable improvements.

As steps on the path to systemic, regional change in the delivery of mental health services, the MHC proposes four specific projects:

- Convene the regional multi-sector leadership to develop a new mental health care strategy
- The Behavioral Health Sciences Center
- Supportive Housing Expansion
- Day Treatment Center for the Seriously and Persistently Mentally Ill (SPMI)

Each project has a Champion, committee members and an action plan.

Purpose

The purpose of this report is to:

- Paint the regional mental health services picture for easy viewing
- Describe, concisely, the extent of the problem
- Call the community to corrective action
- Inspire more people to participate in the effort to change and improve services

Coordination and Deployment of Services

The MHC believes there is an opportunity for local leadership to improve the coordination and allocation of mental health services resources. The prison system competes with local public and private sources for mental health professionals in a zero sum game with no entity responsible for comprehensive services for all citizens. The mentally ill population is not cared for in any coordinated manner because there is no one entity with responsibility for the whole. Patients are often referred to the system and passed about the system rather than managed and treated by the system. Two-thirds of the population goes untreated, effective prevention programs go unfunded and undeveloped, jails are overrun and overcrowded and root causes go unaddressed.

Commitments and Assumptions

In any effort, it is important to make explicit underlying assumptions. In terms of the Mental Health Cluster, the following assumptions guide the work:

- Advances in the understanding mental illness, both in terms of causation and healing approaches, move faster than the means to prepare practitioners and deliver services. The MHC seeks to improve mental health services by executing a plan based upon broad-based understanding of mental health issues and a distributed model of services that includes easy access, peer support, empowerment and recovery. In addition, through one its priority projects, the Behavioral Health Sciences Center, the MHC seeks to infuse the latest, evidence based practices into clinical training and ongoing professional development.
- Mental health exists along a dynamic continuum and both the individual and community can play an important role in enhancing its quality over a lifetime. Mental health is everybody's responsibility. Wellness initiatives within organizations and in the broader community result in improved health and wellbeing, lower utilization of emergency rooms, increased worker productivity, decreased costs of long term care and hold great promise for decreased use of the criminal justice system.
- Prevention and early intervention are top priorities and can only be achieved through community-wide education and collaboration.
- As a diverse community with diverse cultures and high levels of poverty, improving the public's mental health will require interdisciplinary training for professionals and broad public education and support.
- The MHC is committed to working in accordance with the ten community values reprinted at the end of the report.

Definitions

Mental Health: "Ability to cope with life's stresses, work productively, and have fulfilling relationships."

Mental Disorder: "Any health condition characterized by alterations in thinking, mood, or behavior that results in distress or impaired function."

Mental Illness: Defined in the MHSA guidelines as Seriously Emotionally Disturbed (SED) and Seriously Mentally Ill (SMI).

Prevention: "Prevention is work that promotes mental health, intervenes early to address emerging health problems, and reduces the devastating impact of mental illness."

Homeless: The term "homeless" or "homeless individual or homeless person" includes—

1. An individual who lacks a fixed, regular, and adequate nighttime residence; and
2. An individual who has a primary nighttime residence that is —
   a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
   b) an institution that provides a temporary residence for individuals intended to be institutionalized; or
   c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

Supportive Housing: Supportive housing is a combination of housing and services intended as a cost-effective way to help people live more stable, productive lives. Supportive housing works well for those who face the most complex challenges--individuals and families confronted with homelessness and who also have very low incomes and/or serious, persistent issues that may include substance abuse, addiction or alcoholism, mental illness, HIV/AIDS, or other serious challenges to a successful life.[1] Supportive Housing can be coupled with such social services as job training, life skills training, alcohol and drug abuse programs and case management to populations in need of assistance, including the developmentally disabled, those suffering from dementia, including Alzheimer's disease and the frail elderly.

Population Addressed by the MHC:

a) Serious Emotional Disturbance (SED) - Used to describe mental health disorders such as anxiety, conduct, depression, and eating experienced by children and adolescents 0 to 18 years of age.
b) Serious Mental Illness (SMI) - Diagnosable behavioral or emotional disorder of sufficient duration that results in functional impairment, which substantially interferes or limits one or more major life activities.
c) Mental Disorder - In addition to those who meet the SED/SMI criteria, there are persons whose mental health conditions still require specialty services. Individuals with mental disorders have limitations on daily function and moderate to severe symptoms. Such as a diagnosable DSM IV disorder (i.e. pervasive developmental disorders, disruptive behavior disorders, psychotic disorders, mood disorders, anxiety disorders, somatoform disorders, and eating disorder) that results in impairments of one or more major life activities.
d) Special Populations - Comprised of children, elderly, economically disadvantaged, ethnic minorities, individuals with limited English proficiency, highly mobile children and homeless whose needs may not be fully addressed by traditional service providers or who feel they may not comfortably access and use standard resources available.

Extent of the Challenge

In services for the mentally ill, California trails most states and within California, the Central Valley trails the State (List items below with end notes on sources).

It is estimated that two-thirds of the seriously mentally ill in Fresno County cannot access care of any kind.

- About 22% of the U.S. adult population has one or more diagnosable mental disorders in any given year. The incidence of mental disorders in Fresno County appears to reflect the national statistics.
- Between 5-7% of adults have a serious mental illness in any given year.
- 5-9% of children have a serious emotional disturbance in any given year.
- Mental illness is estimated to be the cause of 59% of economic loss from illness or injury-related productivity loss.*
- Centers for Disease Control and Prevention (CDC) estimate 44 million adults and 13.7 million children are plagued with a mental disorder every year.**
- Fresno County estimated SED/SMI 58,459 (2000) 7.6%
  Served in 2005 21,157 (36%)
  Estimated unserved in 2005 37,302 (64%)

**Investing in Mental Health*, World Health Organization, Geneva, Switzerland: World Health Organization; 2003.

***Office of Minority Health & Health Disparities *[OMHD]* 2007.

Other facts from the World Health Organization:

- Four of the six leading causes of years lived with disability are due to neuropsychiatric disorders (depression, alcohol-use disorders, schizophrenia, and bipolar disorder).
- One in four families has at least one member with a mental disorder.
- The average annual costs, including medical, pharmaceutical and disability costs, for employees with depression may be 4.2 times higher than those incurred by a typical beneficiary. However, the cost of treatment is likely to be offset by a reduction in the number of days of absenteeism and productivity lost while at work.
- In many developed countries, 35-45% of absenteeism from work is due to mental health problems.

Access to mental health services is limited for several reasons:

Shortage of mental health professionals of all levels of training with the notable exception of psychiatric technicians. The shortage is particularly acute with psychologists and psychiatrists, especially child psychiatrists.

Table 1 provides a breakdown of mental health professionals. As one can see, Fresno County has fewer providers per 100,000 compared to the U.S. and California in almost all categories.

Table 1.

Occupations	*U.S. Per 100,000	**California Per 100,000	**Fresno County Per 100,000
Clinical, Counseling and School Psychologists	50.77	56.31	34.56
Marriage and Family Therapists	8.35	17.24	7.80
Mental Health and Substance Abuse Social Worker	40.75	34.22	22.30
Mental Health Counselors	33.40	30.18	43.48
Rehabilitation Counselors	47.09	26.94	12.26
Substance Abuse and Behavioral Disorder Counselors	27.72	25.87	25.64
Psychiatrists	11	16	9
Psychologists	55.4	43	26

*Source: *Bureau of Labor Statistics: U.S Department of Labor, Occupational Outlook Handbook,* 2008-2009 Edition on the Internet at http://www.bls.gov/oco/

**Source: *Employment Development Department: Labor Market Information Division,* 2006 and 2016 Projections on the Internet at http://www.labormarket.edd.ca.gov/

Contributing factors to the shortage include:

- Inadequate number of training facilities
- Inadequate compensation
- Better pay and benefits in prison system
- Inadequate comprehensive support programs and facilities
- Insufficient recruitment of mental health workers
- Insufficient retention of mental health workers

Children with serious mental illness must be sent to the Bay Area for treatment because there is no child/adolescent inpatient unit in Fresno County. Although UCSF is prepared to establish a child psychiatry-training program, the program has not been initiated because of a lack of funding for faculty. Child psychiatrists cannot be recruited because the support programs and services needed to properly care for a mentally ill child or adolescent are not in place.

Budget and Funding Issues

Regional public mental health services are largely funded by state sources to the counties. The funding by any measure is inadequate but is nevertheless diminishing and more volatile and fragmented, thereby placing counties in the untenable position of high responsibility and low uncertain funding. In 1991 the formula for funding Mental Health Services was changed and now the majority comes from "Realignment" dollars. This is revenue that is generated from State sales tax and from Vehicle License Fee (VLF), both volatile sources that are subject to wide swings in unfavorable economic times.

Further, the state funding that is available to counties is allocated to multiple programs and the accounting and oversight of each of these categories leads to bureaucratic red-tape. This coupled with the expectation that the services must be rendered up front, but State reimbursement and funding can substantially trail the incurred cost creates budgetary havoc.

The downward spiral of funds has forced the Department of Behavioral Health to take severe cuts. With the cuts for the Fresno County proposed budget for 2008-2009 included there would be a total number of 227 full-time equivalent positions cut over the last 4 years.

Critical Issues for Our Region

- Shortage of mental health professionals
- Shortage of support services/programs to assist mental health professionals
- Fragmented and chronic under-funding of mental health services in the Central Valley
- Emphasis on treatment rather than prevention, jails rather than early intervention
- Shortage of inpatient services, particularly in child and adolescent services
- Shortage of step down, transitional, supportive housing facilities and support programs of all types
- Incomplete public health prevention strategy
- Lack of coordination of services around a central strategy
- Comparatively large uninsured/under-insured population

MHC Strategies to Address Critical Issues

The MHC has concluded that state and county governments will be unable to provide the funds necessary to expand mental health services in the region, insurers and employers are unlikely to correct reimbursement deficiencies and a regional strategy is unlikely to emerge without strong leadership and the participation of all aspects of the community. An atmosphere of creativity and collaboration among various branches of government is beginning but more effective services have not developed. Governments alone are simply too limited by statute and too restricted by inadequate funding to respond creatively to a situation camouflaged by the faded colors of chronic neglect. Regional coalitions must develop to tackle the regional needs and they must include public and private efforts coordinated to propose and implement new solutions to chronic problems.

Prevention

The MHC further believes that more can be done to prevent mental health illness. Prevention is frequently misunderstood. The MHC has adopted this definition:

Prevention is work that promotes mental health, intervenes early to address emerging health problems, and reduces the devastating impact of mental illness.

More can be done in the region at all levels. Those groups at risk for mental illness can be identified and programs can be developed that are less costly than treating the problems that develop when preventive measures are not initiated. For example, 10% of prisoners have severe psychiatric disorders. County jails all over the United States have more mentally ill individuals than any of the facilities in the county that are designed to treat the mentally ill*. Estimates indicate that incarcerating the mentally ill is twice as costly as community treatment programs but communities continue to invest in jails rather than community treatment programs. Fresno County is no exception. Developing adequate housing with integrated support programs keeps the mentally ill out of jail and out of emergency rooms and is far less costly. This is a prevention program that is known to work but we invest in police and jails rather than mental health workers and supportive care.

Another area where prevention programs can be accurately targeted is in children and adolescent services. High risk children are readily identified:

- Children in foster care
- Children with special health care needs
- Children in the juvenile justice system
    a) 60% in need of mental health services
- Children of parents with mental illness
    a) 5X more likely to have severe emotional and behavioral problems

Programs to prevent mental illness in this group can be developed, presumably at less cost than treating advanced mental illness. There is clear evidence, for example, that the incidence of adolescent suicide can be sharply reduced by identifying high-risk adolescents and teaching them new coping skills.

The MHC believes that the coordination of regional services that would come from a new mental health services governance model would lead to a focus on prevention and more effective utilization of mental health designated funds than the current practices. It will therefore continue to explore new models of governance and coordination of services and prevention.

MHC Initiatives

Concurrent with its ongoing explorations of better models of governance and prevention, the MHC has implemented four specific efforts to improve mental health services, all led by a champion.

- Convene a Community Discussion of potential solutions to the deficiencies in mental health services in the region *(Champion Dr. John Capitman)*
- The Behavioral Health Sciences Center *(Champion Dr Scott Ahles)*
- Supportive Housing Expansion *(Champion Leonel Alvarado)*
- Day Treatment Center for the Seriously and Persistently Mentally Ill (SPMI) *(Champion Abdul Kassir)*

1. Community Discussion

We propose that a full day of discussion be organized to bring key mental health professionals, interested citizens, representatives of government and community benefit organizations to begin the process of evaluating how the region's assets can be reorganized and expanded to improve mental health services in the region. Dr. Capitman has begun the process of organizing this vital conference.

2. Behavioral Health Sciences Center

We propose the development of the Behavioral Health Sciences Center ("BHSC") to expand the array of mental health services to those in need in the Central San Joaquin, to train the clinicians needed to provide those services and to attract and retain mental health clinicians from many disciplines.

The BHSC will provide cost-effective, evidence-based, culturally competent services that will focus not only on treatment but also on prevention and recovery. The first step in development of the BHSC will be to open a central clinic/training center. The second step will be to expand services to more distant sites via the development of urban and rural clinics and the use of telecommunication systems.

The BHSC will be committed to a multi-disciplinary treatment and training model. Currently, trainees of the various mental health disciplines train separately with very little interdisciplinary collaboration. The BHSC will develop a 'real world' multi-disciplinary model in which trainees will develop the collaborative skills of interdisciplinary treatment. This integrated educational approach will lead to more comprehensive care of persons with mental illness. This multi-disciplinary approach will also foster the development of support and advocacy programs for those with mental illness and their families.

BHSC Community Benefits

- Enhanced training and retention for a wide variety of mental health clinicians
- Expanded training capacity for existing programs
- Instruction for non-mental health professionals, volunteers of various agencies, parents and families
- Development of a mental health workforce pipeline
- Increased understanding of the causes, impacts, and treatment of mental illness

Training and Retention

In contrast to Southern California and the Bay Area, The Central Valley has had difficulty recruiting clinicians. Because studies have shown that clinicians tend to stay in the area in which they train, especially if there is the opportunity for ongoing training and professional support, we believe the BHSC is critical to any strategy to attract and retain mental health clinicians. The BHSC will be a local training center for:

- Adult as well as child and adolescent psychiatrists
- Clinical psychologists
- Licensed clinical social workers
- Marriage and family therapists
- School psychologists
- Rehabilitation counselors
- Nurse practitioners
- Physicians of various specialties (Family Practice, Internal Medicine, Pediatrics, Ob/Gyn)
- Medical students from UCSF and UC Merced
- Community college mental health degree programs (psychiatric technicians, drug and alcohol counselors, LVN's, medical assistants)
- High school career academics
- Regional occupational center programs

Expanded Training Capacity

Although training programs exist in our area for a number of these professions, many of the programs lack the capacity to expand the number of trainees and also lack adequate clinical training sites to provide clinically relevant training so that graduates can function effectively in a clinical setting after graduation. Because many clinicians must obtain post-graduate training in order to be license eligible and because there is a lack of post-graduate training sites in our area, many graduates from local programs go elsewhere for post-graduate training and then do not return to the Central Valley. The BHSC can reverse this trend by providing post-graduate clinical training for our local graduates and also by attracting post-graduate trainees from other areas to the Central Valley.

Training for Non-Mental Health Professionals

Besides training mental health clinicians, the BHSC will provide mental health education for others including:

- Non-mental health professionals such as police officers, teachers, school staff, probation officers, peer counselors and consumer partners
- Volunteers working in agencies in which mental health issues are encountered: suicide prevention, domestic violence, child and elder abuse and hospice services
- Parents and family members

This level of mental health education provides a means of extending mental health services further out into the community.

Workforce Pipeline

The BHSC will develop a mental health workforce pipeline. People who train in the Valley are more likely to stay here to practice. People who grow up in the Valley and train here are even more likely to stay. Those from the Valley have the added advantage of understanding the culture, demographics and politics of the Valley. A mental health pipeline is a system that identifies students who have an interest in mental health careers at a high school level and provides them with an introduction to those careers at the BHSC. The BHSC will then provide them with clinical experience during their undergraduate, graduate and post-graduate training.

Potential Partners

The institutions that may potentially participate in the BHSC include:

- University of California San Francisco – Fresno Medical Education Program
- University of California Merced
- California State University Fresno – counseling, social work and nursing
- Alliant International University – California School of Professional Psychology
- Kaiser Permanente Medical Center
- Fresno Pacific University
- Fresno County Department of Behavioral Health
- Area community colleges
- Area high schools
- Community Regional Medical Center
- Kings View Corporation (telecommunication)
- Fresno County Office of Education
- Economic Opportunities Commission
- Fresno Business Council
- Work Force Investment Board

3. Supportive Housing

We propose increasing the number of supportive housing facilities within the region. While this effort involves constructing housing, it is much more. The residents of these small housing units require a variety of support systems in order to keep them functional. It has been estimated that the need for supportive housing in Fresno County alone exceeds 2,000 units for the elderly, homeless, mentally ill and disabled, yet there only 2-3% of that estimate are currently planned.

Currently only 2 projects exist in Fresno County:

- Turning Point of Central California (26 beds)
- A privately owned project at Cedar and Dakota with 50 residents

New construction of supportive housing, in addition to renovation of existing sites, must be an integral part of the overall plan.

Recommended Housing Model: Housing First

This proven approach to ending homelessness centers on providing housing quickly and then providing services as needed. What differentiates a Housing First approach from a traditional emergency shelter or transitional housing is that it is "housing-based", with an immediate and primary focus on helping individuals and families quickly access and sustain permanent housing. Housing First programs share critical elements:

- The housing is not time-limited
- A variety of services are delivered primarily following a housing placement to promote housing stability and individual well-being
- Such services are delivered based upon individual need
- Housing is not contingent on compliance with services – instead, participants must comply with a standard lease agreement and are provided with the services
- and supports that are necessary to help them do so successfully

A best practices search of successful Housing First models revealed the following examples:

- Interim, Inc.: Monterey County Health Department Behavioral Health Division, http://www.interiminc.org
- San Diego Mental Health Services Act: http://www.housingsandiego.org
- Sacramento County MHSA Housing Program: Mutual Housing at the Highlands FreitasF@SacCounty.net

- Successful Assistance Program model: The Village Homeless Assistance Program, Long Beach: http://www.village-isa.org
- Successful Recovery Based model: Delancey Street Foundation, http://www.delanceystreetfoundation.org

Unit Model

Single-room occupancy units (SRO). All units will contain a living area, kitchen and bathroom. Complex should be gated to provide safety, with a central courtyard to promote social interaction in a secure environment, a manager's unit, community center and community laundry facility. Projects should be 50 units or less in size, close to public transportation and have retail services within walking distance.

Services

The chronically homeless/SMI population requires services that will likely include a proper diagnosis and medication, case management, clinical care, addiction recovery, dietary planning, housekeeping, payee designation, easy access to transportation, development of social skills, and job search preparation. Peer counseling has proven to be very effective with this population.

Zoning Barriers

On February 12th the City of Fresno submitted their 5-year Housing Element (2008-2013) to the State of California in compliance with SB2 (senate bill passed 10/13/07 requiring local government to identify an inventory of land suitable for housing of low and very-low income families, supportive housing and transitional shelters, by right, with adequate relationship to services). 200 acres of infill property has been identified as potential sites to accommodate the goals set forth in the 10-Year Plan To End Homelessness. However the proposed plan will not work for several reasons. Unless the City of Fresno and surrounding cities change existing land use policies and community plans, new supportive housing projects will not succeed in acquiring the entitlements necessary to be developed. Issues relating to density, parking and underlying zoning will continue to derail development efforts.

Funding of Housing; Importance of Supportive Services

The HUD 811 program provides construction capital and operating subsidies. Additional funding sources are MHSA, CDBG, HOME, NSP, project based Section 8 and grant monies. A comprehensive approach must include service providers in the development of supportive housing.

Potential Temporary Solutions

Some immediate temporary solutions are to re-open the satellite jail and use it as temporary shelter and/or to work with the Fresno Rescue Mission and others to house people in temporary tents.

4. Day Treatment Center for the Seriously and Persistently Mentally Ill (SPMI)

We propose the development of a program to manage the mentally ill population that makes up high utilization of the emergency rooms in the region. Data obtained from Community Medical Centers revealed that there were 363 patients who visited the emergency room more than 8 times in calendar 2008. Over 60% of those patients were discharged with a mental illness or substance abuse related diagnosis. Typically, these patients are dealing with chronic mental health issues and seek basic medical and psychiatric services from hospital emergency rooms. This distinct segment of the medically underserved population bounces back and forth between emergency rooms, board and cares, group homes and homeless shelters while never receiving stabilizing care.

It is our hope that the establishment of a program aimed specifically at the treatment and stabilization of the SPMI population will improve the overall health status of these unique and substantially reduce the cost of their care. The program would be dedicated to using a strengths-based approach to develop the skills and supports necessary to overcome the challenges of psychiatric disorders.

Similar programs in other larger counties (San Diego, Orange, and Los Angeles) treat between 300 to 800 patients at any given time, depending on the level of services and county size. We estimate the program in Fresno would treat between 100 and 200 patients. Mental Health Systems, Inc. (MHS) is a not-for-profit entity out of San Diego which manages some 26 similar programs across the state. They currently manage a program in Fresno aimed at working with the mentally ill who are in and out of the court system. In addition, they have recently acquired the old Hacienda property to be converted into a halfway house for recently released female inmates. Initial discussions have taken place regarding their interest in managing a day treatment program in Fresno County. Funding for the program would come from a combination of sources, including grant dollars, area hospital contributions, patient contributions (Medi-Cal, SSI) and potentially Fresno County MHSA monies.

The following is an outline of the basic program components:

Facility
The facility should be located near public transportation and include a reception area, drop-in lounge, activity room(s), group room(s), and offices for case managers and other professional staff. The primary purpose of the facility is to house the program and provide an attractive environment that sustains attendance to assure adherence to the treatment plan and medication compliance.

Psychiatrist
A psychiatric will serve as the Medical Director of the program, whose primary duties will include:

- Psychiatric evaluation and medication management services
- Inpatient evaluation and treatment of members when hospitalized
- Participates in treatment planning and case management activities

This individual would also provide at least 10 hours of outpatient services per 100 patients in the program.

Social Worker (LCSW or MFT)
The social worker will serve as the program administrator.

Case Manager (BA is Psychiatry or Social Work, LVN, LPT)
One case manager will be assigned to between 20 and 70 patients, depending on level of care. Their primary responsibility is to monitor and facilitate compliance with the treatment plan established by the psychiatrist. Other duties include:

- Monitors and facilitates compliance with treatment plan
- Facilitates Active Community Treatment for case load
- Assists members with financial, legal, housing and social issues
- Leads psycho-educational groups
- Assists with referrals and coordination for vocational education
- Participates in treatment team meetings

It is our goal to have a center up and running by no later than January of 2010. No specific site has been identified to date, but ideally, a site will be located downtown, near public transportation.

While the Day Treatment Stabilization Program focuses on only a very small segment of the population, they are those who are most in need. Small improvements to their lives can have a positive, cascading impact to the whole community.

Conclusions

The MHC has identified a number of gaps in mental health services in the Central Valley. Such shortages are typical of most communities in the United States but they are more acute in the Central Valley.

- Lack of coordination of services around a central strategy
- Shortage of mental health professionals
- Shortage of support services/programs to assist mental health professionals
- Emphasis on treatment rather than prevention, jails rather than early intervention
- Shortage of inpatient services, particularly in child and adolescent services
- Shortage of step down, transitional, supportive housing facilities and support programs of all types
- Chronic under-funding of mental health services in Central Valley
- Incomplete public health prevention strategy
- The government funding shortfall and lack of insurance coverage are unlikely to improve
- Services are unacceptably inadequate
- The status quo is unacceptable
- The region must take responsibility for developing a plan of correction
- The MHC proposes four initiatives:
    a) The convening of all the critical mental health service groups, government, community benefit organizations (not for profits), mental health professionals, and citizens committed to improving the delivery of services to develop a plan of improvement of mental health services in the region
    b) The Behavioral Health Sciences Center
    c) Supportive Housing
    d) Day Treatment Center for Seriously Mentally Ill

The MHC believes new regional strategies; new governance and new implementation models directed at root causes rather than on post-traumatic treatment are needed. County government alone cannot improve mental health services because of restrictions in funding and the limitations of the government regulatory process. A new oversight planning and governance model is needed, one that includes county and city governments, but also local health care providers, school districts, law enforcement and the private sector. Each sector has valuable experiences, perspectives, skills and resources to contribute. But there exists no model to bring out the best the region has to offer, to spark innovation and collaboration, to redefine, to challenge, test and change, to permit the various sectors to contribute their ideas and to coordinate and improve services. Without a new approach, a new public/private model, built on the Core Values of the Fresno Region, a Master Plan developed by all the sectors and accountable to all the sectors, services will continue to be what they have been to date, compartmentalized and inadequate. The MHC believes the region is capable of much more than the status quo and calls upon all the existing providers and interested citizens to develop a new model of mental health services for the region. In today's environment of critical funding shortages the challenges are great but the needs are greater. We have the skills and resources to address this problem. Let's get started.

Mental Health Cluster Participants

The following individuals served on the Mental Health Cluster. In addition, many other citizens were interviewed for facts, ideas and recommendations:

- Scott Ahles, MD., Chief of Psychiatry, UCSF Fresno
- Leonel Alvarado, President, Century Builders, LLC.
- Lee Ayres, Community Builder
- John A. Capitman, Ph.D., Executive Director, Central Valley Health Policy Institute
- Hon. Hilary Chittick, California Superior Court
- Matt DeSoto, MD. Psychiatrist, Bio-Behavioral Medical Clinics, Inc.
- Sal Gonzales, Consultant
- Hon. David Andrew Gottlieb, California Superior Court
- Ed Kashian, Executive Director, Lance-Kashian and Company
- Abdul Kassir, Senior VP, Managed Care, Community Medical Center
- Deborah J. Nankivell, CEO, Fresno Business Council
- D. Duane Oswald, President, Avante Health
- Alan H. Pierrot, MD., Chairman, Mental Health Cluster
- Susan Wynne, Community Development Director, Century Builders, LLC.