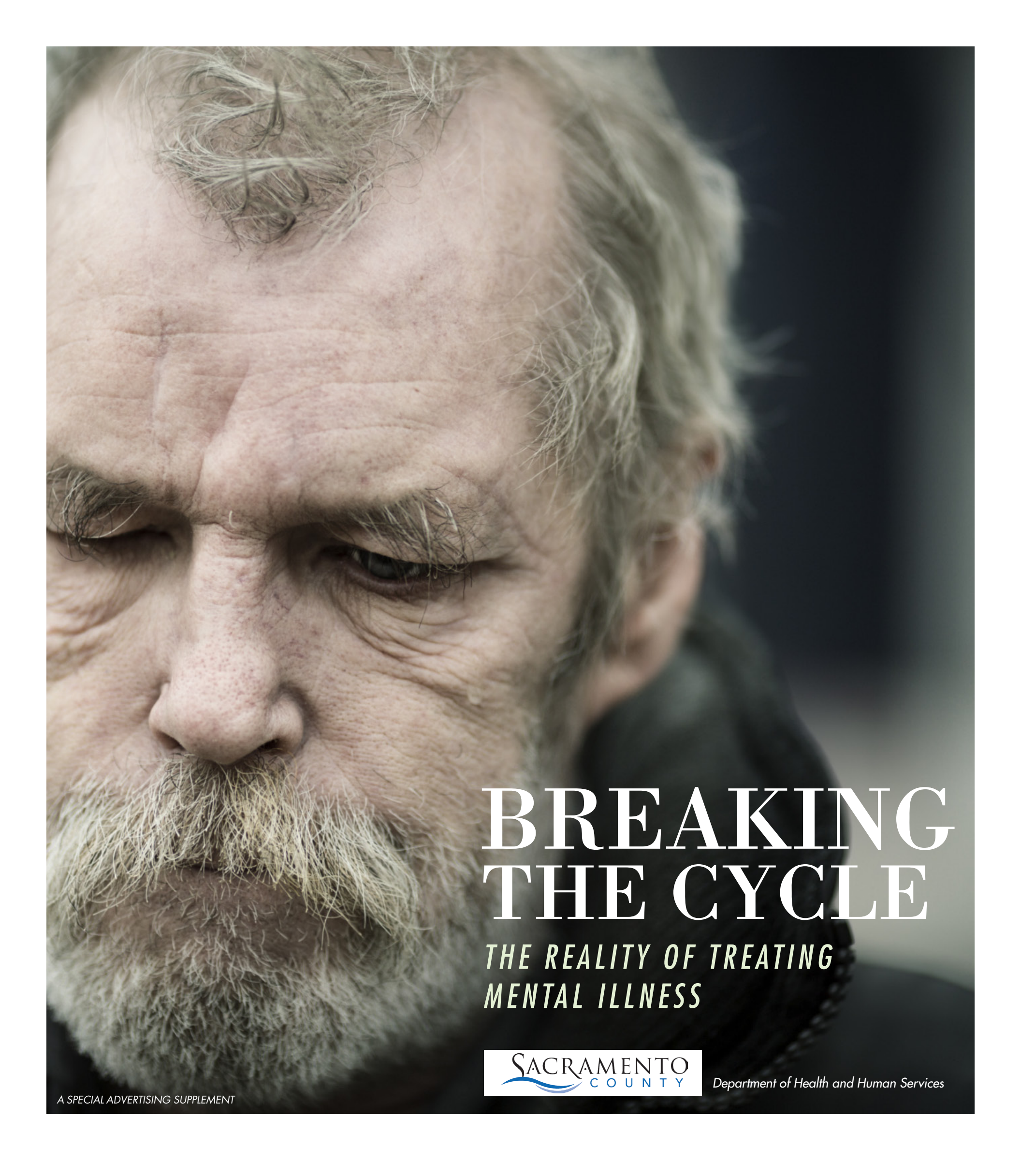




BREAKING THE CYCLE

*THE REALITY OF TREATING
MENTAL ILLNESS*



Department of Health and Human Services

A SPECIAL ADVERTISING SUPPLEMENT



PHOTO BY TARAS GARCIA

A Community Approach to Addressing Mental Illness

HOSPITALIZATION, HOMELESSNESS AND JAIL ARE NOT THE ONLY OPTIONS

BY CLAUDIA MOSBY

TO OUR NEIGHBORS:

We welcome the opportunity to advance the conversation in our community about the ways people living with mental illness and psychiatric disabilities can receive a full range of support and treatment. It's a complex problem that deserves a real conversation.

Will more hospital beds be the solution? Psychiatric hospitalization has its place, and it's an essential and vital service for our community. But, in some cases, there are highly effective, less traumatic, more cost-beneficial ways to help individuals through a psychiatric crisis without involuntary hospitalization or institutional care.

So let's talk about the public cost of beds in large hospitals vs. small ones. Let's talk about programs that teach people skills for being safe and productive when hospitalization is over. Let's address the anxieties of family members who know a partner or child needs help and those of the loved ones determined to control their own lives and treatment. Instead of focusing on, "Why can't we find hospital beds for these people?" let's have a serious conversation about the financial, practical and deeply personal realities of doing so. Let's provide services that reduce trauma, stabilize crisis at the earliest possible point and avoid emergencies. Let's build a system that successfully links people to community supports and follow-up in ways that are cost-effective, promote recovery and stop the cycle of repeated crises.

Respect and understanding, eliminating stereotyping and stigma, and public safety depend on our willingness to advance the conversation. You'll see in these pages the successful outcomes that are achievable when we do.



Sincerely,

Sherri Z. Heller, Ed.D.
Director

**Sacramento County
Department of Health
and Human Services**

A man with paranoid delusions assaults his landlord. A woman threatens to kill herself by jumping off a bridge. An unkempt man loiters in front of a business, muttering to himself and preventing customers from going inside. Individuals like these who experience a mental health crisis can end up with three outcomes: homelessness, hospitalization or incarceration. Many would agree that involuntary hospitalization and incarceration for serious mental illness are sometimes necessary, when the individual is a threat to himself or others. Many would argue, however, that they are not the only — or frequently even the best — options.

A better alternative involves having a broad spectrum of treatment options that can prevent crisis situations and the need for higher intensity — and higher cost — services such as psychiatric hospitals.

"I am a big fan of the de-institutionalization process," says Amy Barnhorst, M.D., associate director of Crisis Services at Sacramento County Mental Health Treatment Center. "I see a lot of people who need outpatient or family counseling, a domestic violence shelter, or a drug and alcohol program. We don't need more people on involuntary holds who quickly get shunted to the highest level of care when they don't always need it."

Dr. Robert Hales, medical director of Sacramento County Mental Health and a professor and chair of the Department of Psychiatry and Behavioral Sciences at UC Davis, echoes Barnhorst's views. "Many patients go to the ER and then are placed on a 5150 [involuntary hold] because there are not enough services provided," he says. "ERs are becoming de facto places of mental health treatment."

This is true not only of ERs but also county jails, where Hales estimates 16 to 18 percent of inmates are on psychiatric medications. "Often they are arrested for something related to their mental disorder," he says. "Someone suffering from schizophrenia may forget to take medication, have delusions or hallucinations, become combative and then be placed in jail. Once back on the medication, those symptoms go away. They don't need to be locked away but perhaps will need short-term intensive services and/or some outpatient follow-up."

Incarceration can further traumatize someone with mental

illness, Hales adds.

"There are many different manifestations of psychiatric illness that do not require hospitalization or incarceration. They do respond to intervention," he says.

Early intervention, education and comprehensive care combined with ancillary services like job training can decrease the likelihood of a person developing a chronic mental illness.

Sacramento County Behavioral Health has had to be creative with its resources to provide these services. But it's not the only service provider having to do so. Hales explains that UC Davis Medical Center has hired more case managers, crisis social service workers, and psychiatric professionals to meet the need. This is

true for all emergency health care systems in Sacramento. Furthermore, Sacramento County Behavioral Health has partnered with many local agencies at all levels of care to deliver outpatient services that support consumer independence.

Turning Point Community Programs is one such partner organization. Among its offerings are comprehensive, early intervention and response services for children and adults with behavioral health or psychiatric disorders. Al Rowlett, Turning Point's chief operations officer, says these services can help prevent hospitalization and keep families together, resulting in cost savings to the taxpayer. Furthermore, the services are offered in places and

at times when they are most needed.

"Evidence suggests that when people with psychiatric disabilities get support in their communities, the outcomes are better," Rowlett says.

Turning Point also offers short-term housing through its residential Abiding Hope Respite Center and assistance to clients in securing permanent housing through its Pathways program.

Having options such as Turning Point helps create the best possible outcomes for individuals of all ages — children, adults and older adults — living with mental illness in the community.

"If we are able to beef up our outpatient systems, we can reduce our inpatient admission rates," Barnhorst says. "Often people cannot get to their appointments or they do not get timely follow-up and end up back in the ER. The most humane way our system can function is not to abolish but to minimize involuntary psychiatric hospitalization."

**"Evidence suggests
that when people with
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AL ROWLETT,

CHIEF OPERATIONS OFFICER FOR
TURNING POINT COMMUNITY PROGRAMS

“I am now back in the swing of things. I’m living with my mental illness.”

LESLIE NAPPER,

TURNING POINT COMMUNITY PROGRAMS CONSUMER

The Road to Wellness

TREATMENT, WHETHER THROUGH HOSPITALIZATION OR OUTPATIENT SERVICES, IS KEY TO MENTAL HEALTH

BY MEREDITH J. GRAHAM

Leslie Napper remembers her time spent in a local mental hospital. She’s never been to jail, but she suspects it’s sort of like that.

“In the beginning it was very scary. I didn’t understand what was happening to me,” she says. “We were in a lock-down situation, and I was in crisis and surrounded by other people in crisis. No matter how many times you’ve been there, it can be a scary place.”

Napper ended up in the mental hospital after her bouts of depression, which she’d dismissed as life’s usual “ups and downs,” took a dramatic turn. She first went to the emergency room and was then admitted to a mental hospital, where doctors kept her for several weeks against her will.

“I did receive the care I needed, though I didn’t recognize it at the time,” she says. While in the hospital, she was diagnosed with bipolar disorder, which often leads to unusual shifts in mood, energy and ability to perform day-to-day tasks. “While I was there, I found a medication regimen that worked for me. Through that and going

through group therapy that they had and learning coping skills, I was able to leave the hospital and do my best to try to resume a good quality of life.”

Before leaving the hospital, Napper was linked with Turning Point Community Programs, which offers outpatient mental health services including support groups, therapy and coordinated case management.

The difference between being a hospital resident and being able to live at home and receive ongoing care was like night and day for Napper. But she recognizes that without the hospitalization and the ongoing support she receives through Turning Point she might not be the healthy, happy person she is today.

“It took me a long time to accept the fact that I had a mental illness. I had to remove the self stigma, which took education, and also step over barriers of stigma from others — it’s terrible the stigma that people with mental illness deal with,” she says. “Once I accepted that I needed to maintain my wellness, and work at it every day, things



Leslie Napper advocates for local mental health services because she knows firsthand how much they can help.

PHOTO BY LOUISE MITCHELL

started to fall back into place. Relationships with my family started to mend, and I started to feel better about my life.”

Napper is now an advocate for respite services and a member of the Mental Health Services Act Steering Committee, whose mission is to ensure Sacramento County residents have access to programs to

improve their mental health. She advocates because she knows what a difference those programs can make.

“I am now back in the swing of things. I’m living with my mental illness,” she says. “But I couldn’t have done it without the continued support of my family and my outpatient treatment team.”

Involuntary treatment and patients’ rights

In California, a person can be involuntarily committed for treatment by a peace officer, medical professional or other professional designated by the county. An initial 72-hour emergency hold is often referred to as a “5150” (short for section 5150 of the state Welfare and Institutions Code) and allows for treatment and evaluation of an individual’s

mental health condition. The patient must either be found to be a threat to himself or others or gravely disabled due to a mental health condition.

After that 72-hour hold, if the person is determined to need further treatment, he can be involuntarily committed for up to 14 days. In addition to being committed to an

institution, a person with a mental illness who has demonstrated that he likely will not survive safely without supervision can be placed on a temporary conservatorship.

Both involuntary and voluntary patients have the right to refuse treatment, except in emergency situations.

Building Trust in Treatment

'MODERATE INTENSITY' SERVICES HELP MAN LIVE INDEPENDENTLY IN COMMUNITY

BY CLAUDIA MOSBY



Jason Moody says support from his mother, Kathy Moody, has helped him recover from mental illness.

PHOTO BY RON NABITY

Crawling around on his elbows in a dark condominium as if he were traversing a war zone, Jason Moody believed in the delusion that he was a prisoner of war. He thought shooters surrounded his home and the military was searching for him.

"Because my [psychotic disorder] was late onset, I was in denial whenever someone told me I was mentally ill," he says. After suffering frequent involuntary commitments, the last due to a violent episode in which he destroyed belongings at his home, Moody came into contact with a social worker from Human Resources Consultants (HRC) who offered him involvement in its Transitional Community Opportunities For Recovery and Engagement (TCORE) program.

"I thought she was an actress, part of a government conspiracy," Moody says of the social worker. "I was so ill." He remembers her telling him that she knew others who had some of the same thoughts and beliefs he had. "It opened the door for me to trust her and take an interest in my own mental illness and recovery," he adds.

According to Program Director Marilyn Sepulveda, TCORE referrals come either directly from hospitals or as a step down from higher intensity Full Service Partnerships or a step up from lower intensity Regional Support

Team (RST) outpatient services. "Most consumers are sent to us because they are difficult to engage, have had multiple hospitalizations, or both," she says.

Viewed as "moderate intensity," HRC's community treatment options are designed for clients who need at least monthly therapeutic support as well as assistance with doctor appointments, referrals to community resources, and goal setting to help them remain

employment and vocational goals so that this doesn't become a lifetime service for them."

In addition to employment and benefits specialists, HRC offers consumers access to therapists, support groups, personal service coordinators and consumer family advocates.

Family is important in recovery, and Moody has received plenty of support from his mother, Kathy Moody. Kathy Moody moved to the Sacramento area from out of state to be an advocate for her son when he was hospitalized. She says she learned a lot about mental illness from Family-to-Family, a free course offered by the National Alliance on Mental Illness for family and caregivers. Kathy Moody says she's thrilled her son is taking responsibility for his treatment and found the resources to help him live in remission.

"I'm doing cartwheels over it, I'm so proud," she says. "This is the longest time in a great while he's been Jason. It's like having him back."

Jason Moody has been with TCORE six months and says his experience has been transformative. "Before, I felt like an outcast. Today I'm meeting people and developing a social life," he says. "I have a mental illness, but I'm not ashamed to admit it. It's in remission and that's thanks to TCORE for being honest with me and me being honest with TCORE. Honesty is really important when someone is trying to help you."

"We're trying to reach the younger adults earlier ... so that this doesn't become a lifetime service for them."



MARILYN SEPULVEDA,
TCORE PROGRAM DIRECTOR

independent in the community. The program serves all of Sacramento County with 740 active clients currently.

"For an outpatient program, we serve a high percentage of transitional youth ages 18-24," Sepulveda says. "We're trying to reach the younger adults earlier and work with them on

Mental Health Services Continuum

Serving the mental health needs of the community requires a robust spectrum of services that ranges from prevention, low-, moderate-, and high-intensity outpatient and community-based care to emergency and long-term residential care programs.

PREVENTION AND EARLY INTERVENTION

These programs are available for children, transitional aged youth, adults and older adults. They are designed to address suicide prevention and education; strengthening families; integrated health and wellness; and mental health stigma and discrimination reduction.

LOW TO MODERATE INTENSITY CARE

These programs are designed to serve individuals living with serious mental illness who have a diminished capacity to attend to their daily activities and relationships. Services are provided both in a clinic setting and in the community and offer a full array of professional, clinical and peer support services.

LESS INTENSE

Whatever it Takes

FULL SERVICE PARTNERSHIP OFFERS HOUSING, TREATMENT TO HELP WOMAN TRANSITION FROM CRISIS



Hermanda Seals was frequently hospitalized for schizoaffective and borderline disorders until she found treatment in a Full Service Partnership, Sacramento Outreach Adult Recovery (SOAR).

PHOTO BY RON NABITY

BY CLAUDIA MOSBY

With commitment, effort and time, individuals with even the most debilitating psychiatric disorders can live independently. Persistence, however, is key. Just ask Hermanda Seals.

Seals, who has schizoaffective and borderline personality disorders, ran away from a board and care home where she was verbally and physically abused. Distraught, she called her therapist. “I told her I was going to run into traffic and she called the police who came and got me,” Seals says.

She was referred to Sacramento Outreach Adult Recovery (SOAR), a program of Telecare Corporation. Seals admits change did not occur overnight. “In the beginning the hospitalizations continued for maybe six months, but then the [treatment] started to take hold. My hospitalizations decreased and my anger got better.”

SOAR is what’s known as a Full Service Partnership and is designed for individuals with a history of frequent psychiatric hospitalizations, a co-occurring substance abuse disorder, and/or a history of homelessness. Members utilize services for as long as needed, but usually no fewer than 12 months.

Members can access a full spectrum of services, including individual and group therapy, medication education and support, and employment, housing, vocational, educational, and money management assistance. Full Service Partnerships adhere to a “do what it takes” philosophy to

“On average, 75 percent of our members do not return to psychiatric hospitalization within a given year.”



SHANNAN TAYLOR,
SOAR PROGRAM ADMINISTRATOR

provide members whatever assistance they need to help them transition to living independently.

Seals found relief using dialectical behavior therapy (DBT). The evidence-based therapy merges Eastern and Western philosophies to help members actualize hopes

and dreams. “We know that hope can motivate change,” says Shannan Taylor, MFT, SOAR program administrator. “On average, 75 percent of our members do not return to psychiatric hospitalization within a given year.”

The therapy balances acceptance and change strategies, but emphasizes mindfulness and acceptance of oneself while participating in the change process, Taylor says.

SOAR’s program serves 150 adults in the Sacramento area. With 80 percent of services delivered individually in the community, Taylor says staff can observe earlier the behavioral changes leading to relapse and intervene appropriately to avoid psychiatric hospitalization.

“We might be on the corner of W street because we haven’t seen a member for a while and know that might be where they hang out. We want to try and re-engage them in services and prevent a relapse,” Taylor explains. “Not all programs offer this level of support.”

A SOAR member for 3 1/2 years, today Seals leads a life free of suicide attempts and repeated hospitalizations. “I am a lot happier and calmer,” she says. “I have plans and look toward the future. I hang out with my boyfriend; I have friends. I like sports and played on the Special Olympics.”

Importantly, at age 34, Seals feels treated like the adult that she is. “Telecare wants to work you towards independence, not having to rely on people,” she explains. “I really like that. I like that they let me make my own decisions and value confidentiality.”

HIGH INTENSITY FULL SERVICE PARTNERSHIPS

These programs serve individuals living with serious mental illness along with co-occurring substance use and medical conditions. Individuals frequently utilize emergency departments and inpatient psychiatric hospitals, interface with the criminal justice system and experience homelessness. These programs offer 24-hour flexible in-home, community and clinic-based support; individual care management; crisis supports; housing resources; medication monitoring; rehabilitation services and vocational opportunities.

ACUTE PSYCHIATRIC CARE AND CRISIS RESIDENTIAL CARE

These programs offer psychiatric stabilization services and outpatient residential services for individuals either in the midst of a crisis or recovering from a crisis episode. Services are offered for a limited amount of time.

SUB-ACUTE CARE

Offers a continuum of care ranging from Transitional Residential Programs to State Hospital level of care. These services are available for individuals who are unable to live independently with lesser supports in the community.

MORE INTENSE



Officer Andrew Bates of the Folsom Police Department recently attended Crisis Intervention Training (CIT). Several police departments in Sacramento are implementing CIT training to provide police officers the tools to identify mental health issues in the field and resolve them without incarceration.

PHOTO BY LOUISE MITCHELL

A Different Approach

TRAINING HELPS LAW ENFORCEMENT UNDERSTAND MENTAL HEALTH ISSUES

BY MIKE BLOUNT

A man lingers in front of a business in Sacramento for several hours. The owner calls the police.

Instead of the responding officer asking the man to leave, he starts a dialogue with him, gains his trust and then asks him what he can do to help.

This technique is just one of many police officers are learning during Crisis Intervention Training (CIT), a program designed to educate law enforcement officers on mental illness and mental health services in the community. Several police departments in Sacramento are implementing CIT for police officers this year.

"The program gives officers more tools to deal with mental illness in the field," says Folsom Police officer Andrew Bates, who attended a CIT course in 2013. "When I went to police academy 13 years ago, most of the training revolved around how to talk to someone who is suicidal. CIT teaches officers how to deal with people who do not need detention, but who need

a referral to mental health services or someone who can stabilize them."

Traditionally, police departments have had little training regarding mental illness. Bates says police feel the need to maintain law and order, so they restrain individuals who are acting erratic or unpredictable. This results in more mentally ill individuals ending up in jail.

"We're learning the best practices to help someone in crisis."

OFFICER ANDREW BATES,
FOLSOM POLICE DEPARTMENT

According to the Sacramento County Jail, about 30-34 percent of inmates receive some form of psychiatric care. Bates says the attitude of law enforcement toward mental illness is slowly changing as more police officers are exposed to CIT.

"A lot of the training is awareness of the different mental health conditions that are out there and what techniques work best for officers to build a rapport and best assist the person," Bates says. "But one of the components is a panel discussion with members of the National Alliance on Mental Illness and people who have had past interactions with law enforcement."

Bates says hearing from NAMI members and their families on effective ways to deal with mental illness is an invaluable part of the training. For example, an officer may choose to go along with someone's delusions to gain his trust. And once that person gets help, he can learn how to manage his condition and stabilize himself.

Ultimately, Bates says the main goal of CIT is to break the cycle of incarceration and transition people to mental health services — and that starts with the officers on the street.

"If we can get the mentally ill connected to services, it gets them the help they need and frees us up to deal with criminal issues," Bates says. "[Through CIT] we're learning the best practices to help someone in crisis and keep everyone safe, but do it in a manner that best serves everyone involved."

New Partners with Law Enforcement

In-House Training

Sacramento County Behavioral Health Services has launched a number of promising partnerships with law enforcement. Regular, in-house training for all officers and sheriffs is now in place. The training includes a BHS team reflecting the family members', clinicians' and consumers' perspectives. Mental health awareness training for police officers in Sacramento County is just a start. Sacramento County Behavioral Health hopes to implement two additional programs that will connect mental health services to the law enforcement system.

Mobile Crisis Support Team

Mobile crisis teams are a partnership between behavioral health and law enforcement to address crisis situations directly in the community. The goal is to get people help sooner with better outcomes.

Navigators

To break the cycle of incarceration and hospitalization, Navigators work with individuals struggling with mental health issues at the jail, Emergency Rooms and homeless shelters, and help them get connected with community services and build a plan for self-sufficiency. The grant money provides funding for Navigators at Sacramento County Jail 24 hours a day, seven days a week.



From left, Stephen Davidson, program manager for contracted services, Dorian Kittrell, director for Behavioral Health Services, and Jeff King, senior administrative analyst, work closely to meet the needs of the community with the appropriate funding sources.
PHOTO BY LOUISE MITCHELL

A Balancing Act

PROGRAM DIRECTORS HAVE TO CONTEND WITH FUNDING RESTRICTIONS WHILE PROVIDING A BROAD ARRAY OF SERVICES

BY MICHELLE CARL

Pretend someone gave you \$100. But it's not in cash — it's a gift card to a clothing store. You would rather use that money on dinner at a restaurant or a new tire for your car, but you can't. There's only one way you can spend that money. This is the challenge faced by Sacramento County Behavioral Health Services. The department receives \$217 million in funding, but there are restrictions on where it can be spent. Certain streams of funding must be used for specific types of services, such as prevention services, or to serve certain populations, such as individuals at risk for becoming homeless. There are also mandates that require the department to

fund emergency and crisis care services, no matter what they cost. Behavioral Health Services has more freedom in spending money it gets from "realigned" sales tax dollars. There's a broad array of services that use this funding, with many stakeholders having different opinions on how it should be spent. "There are so many needs and so many promising ideas to meet those needs, but there's only so much money to fund them," says Dorian Kittrell, director of Sacramento Behavioral Health Services. "Then once you have identified how much something will cost, you need to make sure that how you fund it meets all the regulatory requirements." While an outsider may think, "spend the money where it's needed," it's not

that simple. Take for instance a grant that funds services for the homeless population. Even if a person is at-risk for homelessness because he exhibits mental health symptoms that could cause him to be evicted from his apartment, he may not qualify for services because he technically isn't homeless yet. Directors like Kittrell turn to their "budget gurus" to determine how to match the needs of the community with the appropriate funding. They use data from previous years as well as state projections to estimate future funding that will come in. They also help program directors come up with creative solutions for using both restricted and unrestricted dollars to deliver the network of services. Within that network, there are varying

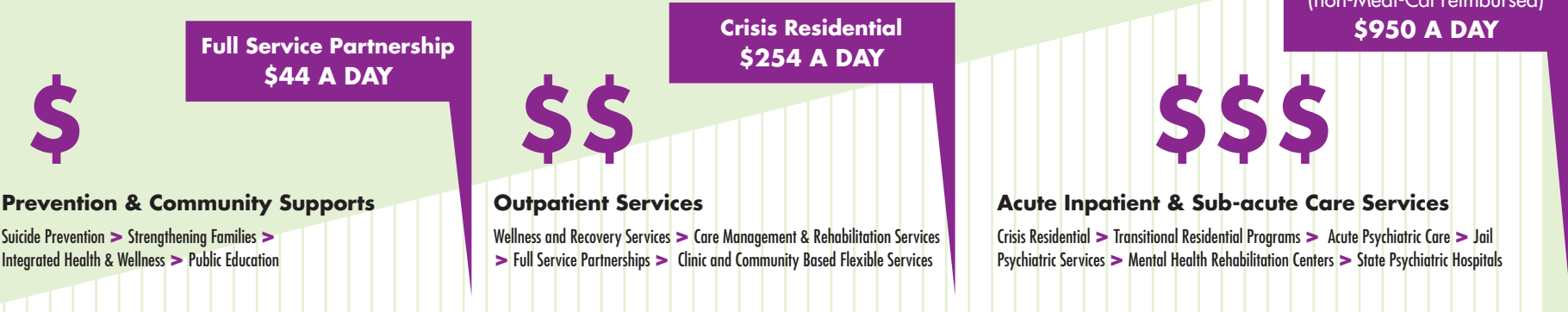
levels of care. The most expensive are psychiatric hospitals that have more than 16 beds. Because of an archaic federal regulation, most individuals treated in this large of a hospital lose their Medi-Cal insurance for all medical care while they are receiving treatment. With no Medi-Cal for these services, the County must pay for 100 percent of the cost of treatment. "So it's in everyone's interest to get inpatient care in a smaller facility or utilize appropriate, alternative crisis services," Kittrell says. "The long-term vision is to have such an array of basic or intensive outpatient services and prevention/early intervention programming, that [it] reduces ultimately the need for more dollars going into the most expensive crisis and hospitalization services."

"It's in everyone's interest to get inpatient care in a smaller facility or utilize appropriate, alternative crisis services."

**DORIAN KITTRELL,
DIRECTOR, SACRAMENTO BEHAVIORAL HEALTH SERVICES**

COSTS ALONG THE CONTINUUM

As the intensity of services increases, so does the cost of providing those services.



More Options. Better Outcomes.

Treating mental illness is complicated. There is no one solution that leads to recovery for every individual. It takes a multitude of treatment options across a spectrum of care. It takes a community of support to help individuals transition to treatment and start the road to recovery.

Contact Sacramento County Behavioral Health Services

Learn more about the broad network of services Sacramento County offers.
www.dhhs.saccounty.net/BHS/

Learn about NAMI Sacramento, the local affiliate of the National Alliance on Mental Illness.
www.namisacramento.org



COSTS OF UNTREATED MENTAL ILLNESS

1 INCREASED HOMELESSNESS

Homelessness can cause people to cycle through hospitals, shelters, jails and the streets, at very high costs to those institutions.

26% of the homeless population lives with mental illness,
 **4X** the rate of the general population.

2 INCREASED COSTS TO THE CRIMINAL JUSTICE SYSTEM

Inmates with serious mental illnesses, such as schizophrenia or bipolar disorder, place a burden on the justice system, when money could be spent on diverting inmates from jail to treatment programs.

30% of female inmates and **15%** of male inmates
in local jails live with serious mental illness.

3 INCREASED COSTS FOR HEALTH CARE

Treating someone with mental illness and a physical condition can result in prolonged treatment and increased costs.

Mental health disorders accounted for **4.2 million** emergency room visits in 2006.


4 INCREASED UNEMPLOYMENT

High unemployment among people with mental illness creates costs for the social welfare system and keeps individuals from realizing their earning potential.

 Between **60% and 80%** of people who live with mental illness are unemployed.

5 HARMING THE DEVELOPMENT OF CHILDREN

On average, children receive treatment 8 to 10 years after the onset of mental illness, impacting critical development years.

One in 10 children suffers from mental illness that impacts his or her day-to-day life.



6 LOST PRODUCTIVITY IN THE WORKPLACE

Mental illness in the workforce, the most common being depression, results in performance issues, absenteeism and impaired productivity.

Mental illness in the workforce costs employers **\$63 billion a year** in lost productivity.


Source: NAMI factsheets