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ATTACHMENT

For Item

#23

Tuesday, September 27, 2022

PUBLIC COMMUNICATION RECEIVED BY THE CLERK OF THE BOARD

From: Linda L Mimms <lindalmimms@gmail.com>
Sent: Monday, September 26, 2022 7:31 PM
To: FGG, Public Comment
Subject: [External] Behavioral Health Continuum of Care Optimal Care Pathways

Follow Up Flag: Follow up
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September 26, 2022

Dear Board of Supervisors,

After reading and analyzing the proposed Optimal Care Pathway Model, I have some comments/concerns:

Any continuum of care model must include in-patient secured beds for the sickest with schizophrenia and other psychosis spectrum diseases. Acute care beds will always be needed as these serious chronic lifetime medical neurological diseases cannot be prevented. People in our county are not being kept long enough at this level of care to stabilize, rather than just being sedated and ejected. No algorithm can predict the number of secured beds needed at any given time in our county for these patients. By diverting money to lower levels of care, the need for periodic hospitalization to stabilize patients is not going to go away.

It is important to dispel a misinformed perspective by some who will claim that acute and sub-acute mental healthcare treatment facilities are carceral simply because they are restrictive settings. Secure beds are not jail cells and are not carceral. These beds exist at the higher levels of the spectrum of mental health care for those who are the most severely mentally ill, but their purpose is recovery and healing, not punishment.

The concept of prevention used in the report needs clarification. You cannot prevent serious chronic neurological brain diseases like schizophrenia and related psychosis spectrum disorders. However, you can prevent further brain deterioration if a person receives treatment at the inception of symptoms. 50-98% of those with these medical brain diseases cannot recognize they are sick (anosognosia) and cannot seek care voluntarily. I am not seeing this addressed anywhere, and these are the sickest people who are costing our county the most money in homelessness, incarcerations, court costs, police expenses, etc., and most importantly, in human suffering. They have been left out of our county's continuum of care for decades.

We need to address compassionate involuntary care for those who have lost their decision-making capacity. Doctors in the regular healthcare system treat patients with compromised decision-making capacity without requiring a nonmedical dangerousness requirement, judges and attorneys.

Currently, there is a hospital bed shortage that is deemphasized in the report. As we are seeing in our community, psychiatric hospitals are constantly spitting out psychotic people onto the streets with no warm handoff to secure residential treatment facilities. Where is the accountability with consequences? Where is the data highlighting this unacceptable practice? Ask any PERT officer how often they help families build a case over months to get a very sick person into a hospital bed and see them back on the street within hours or before their 72-hour hold is completed. Families are never notified often with disastrous results.

When people leave the hospital or jail unstabilized they need a secured bed with clinical care. Unless nursing homes or other housing options are locked and have adequate therapy with psychosocial supports, people in

psychosis will walk out. Families see this constantly, and then they are back to square one in the fight to get basic healthcare for their loved one.

This is also the case with CSUs which are aimed to help people with lesser mental health conditions, not serious neurological brain diseases with psychosis. People in active psychosis with anosognosia are not well enough to seek out a CSU and will walk out.

Many county resources are being directed at MCRT services, but are they serving our sickest? Families have called them when their adult children were in active psychosis and were denied help, leaving the only option to call law enforcement even though their loved one was not violent. What criteria are being used to determine who gets care? If someone will not volunteer for care, will they just get left as is the current situation? How much money is being spent on the media campaign and is it truly helping the sickest it is targeting? Are longer term health outcomes being collected, measured and analyzed?

Peer Support Training needs to specifically teach peers when to request/require the next level of medical assessment to review the patient's "choice making" process. Without an ability to support the client in access to next higher level of care—based on assessment of choice-making capacity—the expanded community treatment and Peer Support persons will face the same problems families face when the person is housed and needs the next higher level of care

How is "grave disability" to be assessed when the person has the community support services (housing, food, treatment supports)? We need to add a solid definition to this proposed plan of "grave disability." To date, the definition changes depending on the day, time and county official you are speaking with. Until we can change the definition at the state level that reflects psychiatric and medical deterioration, this is a pivotal point that can open the door, or slam it shut as it is now, to lifesaving medical care.

Data has demonstrated that only 10 people have been enrolled in our AOT program under Laura's Law since 2015. By any criterion, this program has been a huge failure to help its intended population: people suffering from untreated psychosis spectrum disorders with anosognosia. Yet our BHS touts it as a success! No, it is NOT a success. But it has the potential to be reworked and save lives, and you have the power to demand the needed changes.

Best practices are not being used and the intent of the law aimed at helping our sickest is being violated. IHOT only accepts those who will volunteer for treatment; families across the county have had their very sick children's cases dropped by IHOT stating they would not accept help voluntarily leading to terrible outcomes. The whole point of effective AOT programs is to help our sickest with anosognosia. This is an in-your-face failure of a potential lifeline for families to get their sick loved ones into lifesaving treatment. Please send a BHS official (other than an IHOT employee) to the National AOT Symposium in San Antonio next month to hear how other counties are implementing successful programs and saving lives.

Recommended Top Policy Actions:

1) Add accountability with consequences/penalties throughout the system, especially with psychiatric hospitals for violating "do no harm" and causing needless suffering, homelessness, incarcerations, and deaths.

2) Add transparent data collection requirements at every juncture to enable evidence-based decisions on resource allocations to the most effective programs. By effective I mean lifesaving and cost effective. Value-based reimbursement is a positive action.

3) Add strict oversight of county contracted agencies.

4) MCRTs: What criteria are being used to determine who gets care? If someone will not volunteer for care, will they just get left as is the current situation? How will those unable to volunteer for care be addressed with their needs met? How much money is being spent on the media campaign and is it truly helping the sickest it is targeting? Is the money the county is spending on the media campaign worth it given the numbers helped? Are we collecting, evaluating, and analyzing data on the long term health outcomes?

5) Define what you mean by prevention in the plan, and how that will be measured?

6) Define all metrics in a way that leads to effective outcomes. Organizations will work to meet a metric because they will be judged by their ability to meet that metric, so it is essential to carefully define metrics upfront.

7) Add a solid definition to this proposed plan of grave disability and require all county officials to adhere to the definition. Work on removing the terrible choice the county is forcing families to make of kicking their loved ones out of the house to wait until they deteriorate from their medical condition to the point of not being able to seek shelter, food and clothing, or getting picked up by police. Can you imagine requiring families to kick out their loved one with Parkinson's psychosis to get the lifesaving medical care they need?

I don't think anyone would disagree that if our community mental health care system truly fulfilled its mission and provided a real continuum of care to adequately serve ALL people with serious mental illness in the county, we would have less need for acute, sub-acute, and crisis care. No one disputes that position, but if changes such as being proposed reduce or almost eliminate the capacity to deliver acute and sub-acute care, the problems you have today will only be magnified in the future.

One last note. We have lumped what we now know through science are serious medical neurological brain diseases into a "behavioral" healthcare system that is not designed to address these patients' treatment needs. Until we have a whole person healthcare system that reattaches the brain to the body, we need to ensure that our most vulnerable citizens receive the medical treatment with supportive services and "housing that heals" they require to live their best lives. "No wrong door" means equitable access for all. It is our duty to help those who cannot help themselves. This is not a civil rights issue—it is a health policy issue. Everyone has a human right to lifesaving medical care. Let's make sure they get the care they need in our county.

Sincerely,

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"What you ignore, you empower."