

37. Record of Threat of Litigation (Closed Session Item E) – Disability Rights California's findings letter to Tulare County, dated August 11, 2022.



Board of Supervisors

COUNTY OF TULARE

CLOSED SESSION ATTACHMENT

BOARD OF SUPERVISORS

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AGENDA DATE: July 9, 2024

CONTACT PERSON: Melinda Benton PHONE: 5596365007

SUBJECT: Record of Threat of Litigation (Closed Session Item E)

REQUIREMENT:

When a closed session is placed on the agenda due to a statement threatening litigation made by a person outside an open and public meeting on a specific matter within the responsibility of the Board of Supervisors, the County's record of the statement must be made available for public inspection as part of the open session agenda packet for that meeting. (Gov. Code, § 54956.9, subd. (e)(5).)

ATTACHMENT:

Disability Rights California's findings letter to Tulare County, dated August 11, 2022.



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August 11, 2022

Via Email

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Re: Disability Rights California's Investigation into Tulare County's Behavioral Health Crisis System and Request for Meeting

Dear Ms. Ortiz and Sheriff Boudreaux:

As you know, Disability Rights California ("DRC") has been investigating how Tulare County ("County") agencies respond to people with mental health disabilities when they are in crisis pursuant to DRC's authority as California's protection and advocacy system. Over the last year, DRC has visited and/or met with leadership and staff from numerous County agencies and mental health programs, including but not limited to leadership and staff from the County Mental Health Branch, Psychiatric Emergency Team ("PET"), Tulare County Sheriff's Office, Tulare County Probation Department, Porterville Police Department, Kaweah Health Emergency Department, Kaweah Health Mental Health Hospital, Sierra View Emergency Department, Turning Point, Kings View, and Wellpath, among others. This letter summarizes our findings and recommendations.

Thank you for your courtesy and cooperation during the course of our investigation. We were encouraged by what appears to be a genuine commitment by key stakeholders to improving behavioral health outcomes in the County. Although there is much work to do, the County's ongoing investments in cross-agency collaboration and crisis service programs provide a strong framework for implementing the recommendations set forth in this letter.

Based on our investigation, which included visits and interviews with patients, County staff, and providers, we have concluded that the County's policies and practices with respect to its crisis services conflict with multiple state and federal laws.

Specifically, we have found that the County fails to provide adequate community-based crisis services and instead employs coercive practices in County emergency departments, hospitals, jails, and during investigations and arrests, resulting in the needless institutionalization of large numbers of adults and youth with mental health disabilities. Many of these individuals remain in institutions longer than clinically necessary, while others are discharged without appropriate community services, putting them at risk of re-institutionalization. These systemic deficiencies conflict with County residents' rights under the Americans with Disabilities Act ("ADA"), Section 504 of the Rehabilitation Act, Medicaid Act, and California law, all of which prohibit discrimination against persons with disabilities and the unnecessary segregation in institutions like hospitals and other locked facilities.

Our findings are supported by the attached report, *Assessment of Tulare County Behavioral Health Crisis Services*, which has been prepared by DRC's consultant and agent, Kappy Madenwald (hereinafter, "Madenwald Report").¹ Ms. Madenwald is a nationally recognized expert in crisis services who has worked with the United States Department of Justice and state and local governments across the country to identify and cure deficiencies in crises service systems in order to improve behavioral health outcomes.²

DRC has also consulted with the Center for Juvenile and Criminal Justice ("CJCJ") to help us analyze findings and develop recommendations relating to the County's criminal system, including findings relating to the arrest and/or incarceration of people with mental health disabilities who could be served in community settings. CJCJ is a California-based nonpartisan organization that partners with national, state, and local jurisdictions as well as nonprofit and advocacy organizations to promote a balanced and humane criminal justice system designed to reduce incarceration and enhance long-term public safety.³

As discussed more fully below, in order to comply with state and federal law, the County must take immediate steps to cease the unnecessary institutionalization of people with disabilities and expand its community-based crisis services, including by

¹ Ms. Madenwald's Report is attached hereto as [Attachment A](#).

² Ms. Madenwald's background and qualifications are set forth on pages 1-2 of the Madenwald Report.

³ CJCJ's website is available here: <http://www.cjcj.org/index.html>.

implementing the recommendations set forth in Ms. Madenwald's Report.⁴ While DRC intends to seek implementation of all of Ms. Madenwald's recommendations, we have prioritized three key remedial measures that were identified by Ms. Madenwald and raised repeatedly by mental health providers and County residents:

- Meaningful Crisis Intervention services. As used herein and in Ms. Madenwald's report, "Crisis Intervention" refers to services that are separate and apart from PET's current function, and that are designed to de-escalate and resolve behavioral health crises in the community without law enforcement involvement or the need for institutional care;⁵
- Voluntary, community-based, peer-led Crisis Treatment⁶ services that provide short-term alternatives to institutional care for crises that cannot be immediately resolved in the community;⁷ and
- Early-intercept criminal-system diversion programs designed to divert people with mental health disabilities away from jail and to behavioral health services before or immediately after arrest.⁸

We intend to seek implementation of these and the other recommendations in Ms. Madenwald's report through effective, durable remedial measures that address the deficiencies identified herein in an efficient and collaborative manner. Although DRC is prepared to seek judicial remedies to address the legal violations we have identified, we propose meeting with you to discuss appropriate remedial measures without the need for costly litigation. ***Please let us know if and when you are available for such a meeting.*** The findings and recommendations we wish to discuss at the meeting are set forth below.⁹

⁴ See Madenwald Report 26-35.

⁵ See Recommendations Two, Five, and Seven in Ms. Madenwald's Report. *Id.* at 28, 30, 32; see also *id.* at 5-6 (defining Crisis Intervention as "unplanned emergency brief assessment, treatment and support" designed to "relieve or resolve crises at a person's home, school, workplace, or other location in the community" in order to eliminate or diminish the need for hospitalization or law enforcement involvement without placing a person on an involuntary hold).

⁶ As used herein and in Ms. Madenwald's report, "Crisis Treatment" includes a "range of short-term voluntary treatment and stabilization services" provided in "home-like, non-hospital environments" that "incorporate Peer Specialists and should provide intensive post-crisis follow up and supports in the community to ensure care access and engagement." *Id.* at 6.

⁷ See Recommendations Four and Seven in Ms. Madenwald's Report. *Id.* at 30, 32.

⁸ See Recommendations Six and Seven in Ms. Madenwald's Report. *Id.* at 31-33.

⁹ This letter sets forth our findings and recommendations. It is not intended to be a confidential settlement communication.

I. The County's Policies and Practices Relating to its Behavioral Health Crisis System Violate State and Federal Law.

A. The County Fails to Provide Crisis Services in the Most Integrated Setting in Violation of the ADA and Related State and Federal Law.

The ADA prohibits discrimination against people with disabilities. 42 U.S.C. § 12132. Under Title II of the ADA,¹⁰ people with mental health disabilities have a right to access treatment and services in the most integrated setting appropriate (the “integration mandate”). 42 U.S.C. §§ 12131-12134; see also Section 504 of the Rehabilitation Act, 29 U.S.C. §§ 794 et seq., 28 C.F.R. § 41.51(d); 28 C.F.R. § 35.130(d) (1991); Gov’t Code §§ 11135-11139.¹¹ Applying this mandate, the United States Supreme Court has held that the unnecessary institutionalization of individuals with disabilities in hospitals or other locked facilities is a form of discrimination prohibited by the ADA. *Olmstead v. L.C.*, 527 U.S. 581, 597 (1999).

Tulare County is responsible for directly providing, or arranging and paying for the provision of, specialty mental health services to Medi-Cal beneficiaries under its Mental Health Plan.¹² Specialty mental health services include Medi-Cal Crisis Intervention,¹³ Crisis Stabilization,¹⁴ and Crisis Residential Treatment services.¹⁵ Under

¹⁰ Title II applies to all “public entities.” 42 U.S.C. § 12131(1).

¹¹ Section 504 of the Rehabilitation Act bans discrimination by recipients of federal funds. 29 U.S.C. §§ 794-794a. It contains the same “integration mandate” and similar prohibitions against discrimination as Title II of the ADA. Likewise, California’s non-discrimination statute prohibits discriminatory actions by the state and state-funded agencies or departments, and provides civil enforcement rights for violations. Cal. Gov’t Code § 11135(b). Tulare County receives “federal financial assistance,” subjecting it to Section 504 of the Rehabilitation Act, and receives “financial assistance from the state,” subjecting it to Government Code Section 11135.

¹² In California, counties are responsible for providing specialty mental health services as described in California’s Medicaid State Plan and Title 9, California Code of Regulations § 1810.247. See also Cal. Welf. & Inst. Code (“WIC”) §§ 14684(a)(6)-(7); Cal. Code Regs., tit. 9 § 1810.345(a).

¹³ Medi-Cal’s statutory definition of “Crisis Intervention” is consistent with the definition used herein and in Ms. Madenwald’s report. Cal. Code Regs., tit. 9 §§ 1810.209, 1840.336; Madenwald Report 5-6, n.9.

¹⁴ Medi-Cal defines “Crisis Stabilization” as a service lasting less than 24 hours for a condition that requires more timely response than a regularly scheduled visit. Service activities include assessment, collateral, and therapy and are delivered at specially-designated facilities. Cal. Code Regs., tit. 9 §§ 1810.210, 1840.338(a); Madenwald Report 6-7 (describing a range of Medi-Cal-billable, community-based Crisis Stabilization options).

¹⁵ Medi-Cal defines “Crisis Residential Treatment” as a therapeutic or rehabilitative services provided in a non-institutional residential setting, which provide a structured program as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis. The services must be provided by specially-licensed and certified programs and must include a

the ADA's integration mandate, Tulare County must provide these services in the community rather than in institutions when appropriate to meet the needs of people with disabilities. 28 C.F.R. pt. 35, App. B (2010); U.S. Dep't of Justice, *Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead*, Q&A 1, 15 ("DOJ Statement").¹⁶ County policies and practices that result in the unnecessary institutionalization of people with disabilities conflict with the ADA and its implementing regulations. *Olmstead*, 527 U.S. at 597. In addition, the failure to provide meaningful community alternatives to institutional care violates the ADA if the lack of community services puts people at serious risk of institutionalization. *M.R. v. Dreyfus*, 697 F.3d 706, 720, 734 (9th Cir. 2012); DOJ Statement, Q&A 6. To be effective and meet minimum standards, services must be culturally responsive,¹⁷ trauma-informed, and person-centered. Madenwald Report 8-9.

In the course of our investigation, we found that the County lacks these essential community-based crisis services and employs practices that cause harmful and unnecessary institutionalization on a broad and systemic scale, due to the following:

- (1) Needless institutionalization of people with disabilities in emergency rooms and institutions, instead of less-restrictive community settings;
- (2) Improper prioritization of PET legal evaluations for involuntary mental health treatment over community-based Crisis Intervention services;
- (3) Over-reliance on law enforcement to respond to mental health crises;
- (4) Holding disabled people in institutions longer than clinically necessary; and
- (5) Arrest and detention practices that result in the over-incarceration of people with mental health disabilities in County jails.

range of services designed to support recovery. Cal. Code Regs. tit. 9 §§ 1810.208, 1840.334(c),(d); Madenwald Report 7 (describing Medi-Cal-billable Crisis Residential Treatment options).

¹⁶ Because Congress directed the Attorney General to promulgate regulations implementing the ADA, the Department of Justice's interpretations of the statute and its own regulations are entitled to deference. 42 U.S.C. § 12134; *Olmstead*, 527 U.S. at 597-98; *M.R. v. Dreyfus*, 697 F.3d 706, 735 (9th Cir. 2012).

¹⁷ Culturally responsive means that services affirm and reflect the cultural orientation of the person being served. Madenwald Report 9-10.

These and other¹⁸ County policies and practices are inconsistent with the ADA's integration mandate and related laws, as set forth below.

(1) *The County needlessly institutionalizes people with disabilities in County emergency departments and institutions rather than less-restrictive community settings, in violation of the ADA.*

During our investigation, we learned that the County's crisis services are largely—and at times exclusively—provided in emergency departments and psychiatric institutions, rather than in less-restrictive community settings. The County's reliance on hospitals to treat people experiencing behavioral health crises disregards patients' right to be served in the most integrated setting under the ADA and harms their health and well-being. *See Olmstead*, 527 U.S. at 597

Data provided by the County shows that, in the year 2020, the County delivered 88% of its PET crisis interventions in emergency departments, hospitals, or jail. Madenwald Report 14. The County's PET service is understaffed and unable to respond to most calls in the community, leading California's Department of Health Care Services to conclude that Tulare County must double its mobile crisis service. *Id.* at 28. During DRC's meetings and interviews, County and provider staff confirmed that PET staff spend the vast majority of their time in County emergency departments and seldom respond in the community where the crisis occurs.

In many cases, the County provides PET services in the emergency department even when the County itself determines that an emergency-level of care is not necessary. For example, the County routinely instructs individuals and law enforcement to meet PET at the emergency department for evaluation—requiring the person to be admitted to an institution before they are even evaluated for County services. *Id.* at 20. As explained by County staff, many of these patients do not need to be at the emergency department, and PET will “clear” the person for discharge if they do not meet criteria for an involuntary hold. This is an admission that these practices cause the institutionalization of people who do not need institutional care. In addition, the very environment and medicalized approach in emergency departments causes significant clinical harm to people in psychiatric crisis, including “increased distress and worsening symptoms.” *Id.* at 15, 24. This in turn creates a serious risk of decompensation and re-institutionalization, in violation of the ADA.

By providing its crisis services in emergency departments and institutions instead of in the community—irrespective of whether the patient actually needs that level of care—the County leaves residents with no other choice but harmful institutionalization for accessing County services. This policy and practice is inconsistent with the ADA. 28

¹⁸ The County's problematic policies and practices are described in more detail in the Madenwald Report. See Madenwald Report 11-25 (detailing ten factual bases for her opinion that the County fails to meet minimum standards of care).

C.F.R. § 35.130(d); *Townsend v. Quasim*, 328 F.3d 511, 514, 518 (9th Cir. 2003) (holding that, where state required medically needy people with disabilities to receive long-term care services “in a nursing home setting or not at all,” the state’s failure to provide such services in integrated community settings may violate the ADA).

(2) *The County’s improper prioritization of legal evaluations for involuntary treatment over meaningful, community-based Crisis Intervention puts people at serious risk of institutionalization, in violation of the ADA.*

Our investigation found that, in providing crisis services, the County improperly prioritizes legal evaluations for involuntary treatment¹⁹ over meaningful, community-based Crisis Intervention. Madenwald Report 12-14 (finding that PET’s primary service function is “evaluating consumers to determine if they are in crisis to the point where they require a 5150”). This is by design, as confirmed during our conversations with County Mental Health leadership and staff, as well as PET training materials, which focus almost entirely on 5150 processes and procedures. *Id.* at 13.

The County’s singular focus on legal evaluations “‘is not a valid approach to addressing a mental health crisis’ and, in many cases, ‘may do more harm than good.’” Madenwald Report 13 (quoting SAMHSA *Practice Guidelines*). This is because approaching people in crisis through coercive processes that could result in a loss of freedom can actually exacerbate symptoms and cause panic, escalating the crisis and leaving PET unable to make informed clinical determinations about the person’s needs. *Id.* at 13-14. In light of this, Ms. Madenwald concluded that the County’s current practices create “a significant risk that the person could be institutionalized or jailed due to the harmful effects of the County’s current treatment modalities.” *Id.* at 14. County practices that put people at serious risk of institutionalization violate the mandates of the ADA. See *V.L. v. Wagner*, 669 F. Supp. 2d 1106, 1119 (N.D. Cal. 2009).

In addition, by focusing PET services on legal evaluations for involuntary treatment, the County leaves residents who do *not* meet WIC § 5150 criteria without any crisis services at all. Ms. Madenwald explained that “[n]ot meeting WIC criteria is not synonymous with any existent crisis being resolved,” finding that the County’s lack of true Crisis Intervention services means that many behavioral health crises may go untreated. Madenwald Report 25. This lack of appropriate services creates a serious

¹⁹ Under WIC Sections 5150 (for adults) and 5585 (for minors), County-designated professionals and officers may take an individual into custody involuntarily and place them in a facility for 72-hour treatment and evaluation. See WIC §§ 5150 & 5585 *et. seq.* Under WIC Section 5250, involuntary commitments may be extended up to 14 days, and beyond that if certain legal criteria are met. See WIC §§ 5260, 5270, 5300, and 5350. Throughout this letter, references to “legal evaluations” and “involuntary treatment” or “holds” are intended to reference involuntary psychiatric commitments performed by the County pursuant to these statutes.

risk of “repeat crises, involuntary treatment, and hospitalization” and is therefore inconsistent with the ADA. *Id.*; see *M.R.*, 697 F.3d at 720, 733 (reduction in community services created serious risk of institutionalization in violation of the ADA); *Oster v. Lightbourne*, 2012 WL 691833 at *16 (same); DOJ Statement, Q&A 6 (“[A] plaintiff could show sufficient risk of institutionalization to make out an *Olmstead* violation if a public entity’s failure to provide community services ... will likely ... lead to the individual’s eventual placement in an institution.”).

(3) *The County’s reliance on law enforcement to respond to mental health crises in the community puts people at serious risk of institutionalization, in violation of the ADA.*

Our investigation found that, by design, law enforcement personnel are the first—and often the only—emergency responders to a mental health crisis in the County. Madenwald Report 19. We found that law enforcement agencies respond to mental health calls far more often than PET, and that law enforcement routinely transports people to the emergency department to access County services. *Id.* at 15, 19. For example, according to County data, in 2020, Tulare County Sheriff deputies responded to 781 incidents involving WIC § 5150 evaluations in the community, compared to only 284 PET responses in community settings.²⁰ *Id.* at 19. County data indicates that the majority of Sheriff mental health responses result in a WIC § 5150 hold. DRC also spoke to County residents who explained that there are only two options if you are having a mental health crisis in Tulare County: go to the emergency department on your own, or call 911 and get a police response—both of which are likely to result in an involuntary hold.

The County’s law-enforcement-first approach contributes significantly to the unnecessary institutionalization of people with disabilities in various ways, often with life-threatening consequences. For example:

- Because law enforcement officers are not clinicians and cannot provide actual treatment, they are likely (and are often instructed by PET) to transport a person to the emergency department for care. Madenwald Report 20. Our review of Sheriff incident reports shows that the vast majority of these emergency department transports are accomplished through involuntary holds. As Ms. Madenwald explained, “[t]hese are coercive, lengthy practices that the County provides as its response of first resort. By subjecting people in crisis to multiple contacts with law enforcement and/or medical staff before they see a mental health professional, the County adds unnecessary layers of fear and anxiety to its service. This in turn risks exacerbating the person’s initial crisis and increases

²⁰ During this same period, PET logged 3,864 crisis intervention contacts in emergency departments and institutional settings.

the likelihood that PET will determine that involuntary treatment is necessary, putting the individual at risk of hospitalization when less-coercive community-based Crisis Intervention modalities could be effective.” *Id.* at 15.

- When responding to emergency calls, law enforcement officers in Tulare are disproportionately likely to arrest people with mental health disabilities, even for low-level offenses. Madenwald Report 20-21. Our investigation found that County arrest rates are *more than double* the state average.²¹ *Id.* at 21. The County’s arrest rates are even higher for communities of color. For example, while Black residents only make up approximately 1% of the County’s population, the County’s 2020 arrest rate for Black residents was nearly *three times* the state average.²² This results in significant racial disparities across the County’s criminal and behavioral health systems.²³ *Id.*
- Law enforcement response to behavioral health crises can have dangerous and life-threatening consequences, particularly for Black residents and other people of color, as demonstrated by the tragic outcomes of recent police responses to mental health crises in Tulare County.²⁴
- In the small number of instances when PET does respond to community settings, County policy is to have PET respond with police. Madenwald Report 20. This policy can have disastrous consequences for the person being served because of the potential for arrest, detention, or worse. Research has shown that the mere presence of law enforcement can escalate a mental health crisis and exacerbate symptoms, which in turn creates a serious risk that law enforcement will determine that an involuntary hold or arrest is needed. *Id.* at 10, 20-21. This

²¹ The Sheriff arrested 5,425 people in 2018, which was 22.4% of total arrests in the County.

²² See Census Reporter, Tulare County, CA (reporting data collected by the U.S. Census Bureau for 2020), available at <https://censusreporter.org/profiles/05000US06107-tulare-county-ca/>; California Department of Justice, *Open Justice, Arrests* (2021); California Department of Finance, *Estimates, Annual Intercensal Population Estimates by Race/Ethnicity with Age and Gender Detail, 2000-2010 and 1990-1999* (2021); State of California Department of Health Care Services, *Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives, and Implications* at 113 (January 10, 2022), www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf (hereinafter “DHCS Assessment”).

²³ Systemic racial disparities can and should be addressed in part through provision of culturally responsive community behavioral-health and early-intercept diversion programs, including but not limited to culturally responsive Full-Service Partnerships, supported housing, and crisis care.

²⁴ See, e.g., ABC30 Fresno, *Mother of man killed by Tulare Police files federal lawsuit* (Aug. 27, 2018); ABC30 Fresno, *Porterville OIS suspect had history of mental illness and drug abuse* (Feb 19, 2020); A.J. Kato, YourCentralValley.com, *Visalia mother shares ‘heartbreaking’ video after police K-9 bit her schizophrenic son* (Oct 26, 2020).

is particularly true for people of color and people who are undocumented. *Id.* at 10 (citing SAMHSA and DHCS).²⁵ As Ms. Madenwald concluded, Tulare County's crisis systems must be able to deliver services in lieu of law enforcement with the goal of reducing or eliminating law enforcement involvement altogether. *Id.* at 11. Law enforcement support and/or co-response teams should be deployed only when the use of law enforcement is legally indicated or otherwise unavoidable.²⁶ *Id.*

All of these outcomes harm people with disabilities and create a serious risk that they will be institutionalized. As Ms. Madenwald explained, "[f]or the person in crisis, what was a request for a healthcare intervention becomes a carceral risk that could have been mitigated if Crisis Intervention teams had responded instead." *Id.* at 21. The County's failure to provide such services is inconsistent with the ADA. See *M.R.*, 697 F.3d at 720, 733. Although the County does not directly control the city police agencies that carry out most arrests, the County exerts significant control over the systemic deficiencies described above. For example, County agencies are responsible for PET policies and practices, as well as the absence of effective diversion programs that would reduce the disproportionate arrest rates.

(4) *The County holds patients in institutions longer than clinically necessary, including through serial, "stacked" 5150 holds, in violation of the ADA and California law.*

In addition to placing patients on involuntary holds even if the person seeks services voluntarily, the County also detains people longer than clinically necessary by placing them on consecutive, "stacked" 5150 holds. Madenwald Report 17. This is often due to a lack of appropriate discharge options, so that staff struggle to find another location for the patient.²⁷ *Id.* County staff estimated that PET re-evaluates emergency

²⁵ See also Bazelon Center for Mental Health Law, *Advancing An Alternative to Police: Community-Based Services for Black People with Mental Illness* at 2 (2022) ("Black people experience heightened surveillance, higher rates of stops, searches, and arrests by law enforcement, and are grossly overrepresented amongst those incarcerated in the U.S. Additionally, Black people are over three times as likely as white Americans to be killed by law enforcement.").

²⁶ The rollout of the 988 Lifeline for behavioral health crises will not address the deficiencies identified herein. Even if the County effectively implements 988, the County's failure to provide meaningful Crisis Intervention and its practices relating to law enforcement response, involuntary holds, and institutional treatment will undermine the effectiveness of the 988 service.

²⁷ Too often, there appear to be only two outcomes for people in crisis, even after prolonged periods spent waiting in the ED: go home with no services in place or be hospitalized for inpatient psychiatric treatment at Kaweah Health Mental Health Hospital or another facility that could be located many miles away. This is due in part to the County's failure to develop appropriate community-based programs designed to keep people out of institutional settings, such as adequately resourced Full-Service Partnership programs and supported housing programs. The County's practice of transferring patients to other psychiatric facilities across the

department patients for serial involuntary holds on a daily basis. *Id.* As a result, patients may be held in the emergency department for days on end. According to Ms. Madenwald, this practice is “particularly harmful to people with complex health needs and minors, for whom County providers report a lack of appropriate alternative placement options. These vulnerable populations may be involuntarily held for even lengthier periods of time if they are unable to be safely discharged home or to an alternative community placement.”²⁸ *Id.* at 18.

The use of “serial” or “stacked” 5150s in order to extend a patient’s hold at emergency departments violates the Lanterman-Petris-Short (“LPS”) Act, which allows for evaluation and treatment under Welfare and Institutions Code (“WIC”) § 5150 “for a period not to exceed 72 hours.” WIC § 5151. At the end of the 72-hour detention under Section 5150, a detained individual must be released, provided treatment on a voluntary basis, certified for intensive treatment under WIC § 5250, or appointed a conservator or temporary conservator. WIC § 5152.

The County’s use of serial involuntary holds also violates the Due Process Clauses of California and U.S. Constitutions. As the Ninth Circuit has explained, LPS commitments implicate “an important, constitutionally-protected liberty interest” that may not be infringed “without complying with minimum requirements of due process.” *Doe v. Gallinot*, 657 F.2d 1017, 1021, 1025 (9th Cir. 1981) (holding that patients have a due process right to a hearing that must occur “in no event” beyond seven days of detention). By holding individuals for extended periods at County emergency departments, the County risks delaying patients’ access to constitutionally required due process. *Id.*; Madenwald Report 17-18. The County’s practice may also violate patients’ right to timely mental health treatment under the LPS Act. WIC § 5325.1 (requiring “treatment services which promote the potential of the person to function independently” and to “prompt medical care and treatment.”); *id.* at § 5250 (after 72 hours, individuals requiring continued detention must receive “intensive treatment”).

Similarly, our findings indicate that people in Kaweah Health Mental Health Hospital—the locked, acute-level inpatient hospital for psychiatric care in Visalia—are being held unnecessarily or longer than clinically necessary due to a lack of services in the community. This practice appears to be particularly widespread for County conservatees, who are routinely held at the acute Mental Health Hospital due to the

state is problematic, as it makes family visitation very difficult, time-consuming, and prohibitively expensive for low-income households.

²⁸ We are also concerned about the County’s high rates of crisis interventions for youth. Because Kaweah Mental Health Hospital does not accept minors, young people may be held in the ED for extended periods while staff attempt to find a placement out of the County. The impact that these practices have on young people are extremely harmful and can be remedied by expanding community-based services in Tulare County. Madenwald Report 18.

County's failure to provide a less restrictive setting, even when they do not need acute inpatient care. This unnecessary institutionalization of individuals with disabilities is a form of discrimination prohibited by the ADA. *Olmstead*, 527 U.S. at 597.

(5) *The County's jailing practices disproportionately impact people with mental health disabilities and put them at serious risk of institutionalization, in violation of the ADA.*

As noted above, the criminal system in Tulare County consistently arrests and/or detains a disproportionately large number of people with mental health disabilities, with arrest rates more than double the state average. We also found that the Sheriff detains people in the jail at rates far higher than the state as a whole.²⁹ And with few alternatives to detention or diversion programs, Tulare residents are incarcerated and sent to state prison at higher rates.

These local arrest and jailing practices disproportionately impact adults and young people with mental health disabilities, resulting in their overrepresentation in County jails. Madenwald Report 21. According to County data for 2021, over half of incarcerated adults and nearly 79% of incarcerated youth were on the County's mental health case load—rates that far exceed the statewide average. *Id.* at 21-22. PET responses at the jail have increased drastically in recent years, from 24 in 2019 to 134 in 2021, approximately half of which resulted in involuntary holds. *Id.* at 23. Based on this and other data, as well as interviews with individuals, Ms. Madenwald concluded the County improperly relies on jails to provide mental health treatment to many residents who could be served in the community. *Id.* at 20-21.

The overrepresentation of people with mental health disabilities in Tulare County jails has dire consequences. In addition to the negative impact of an arrest record, the harsh conditions and minimal mental health treatment available at the jail are especially destructive to detainees' mental health. During our investigation, we learned that the County jail frequently subjects people with mental health disabilities to solitary confinement and provides little-to-no access to programming or meaningful mental health treatment. *Id.* at 22. Ms. Madenwald expressed concern with the "quantity and quality of mental healthcare provided in jail," finding that mental health services are limited to medication, sudoku puzzles, and cell-front suicide checks with no privacy whatsoever. *Id.* People experiencing mental health crises at the jail are not provided with Crisis Intervention and de-escalation services, but are instead treated as a safety risk and held in windowless "safety cells." *Id.* at 23. This has led incarcerated people to avoid seeking mental health care altogether "out of fear that jail staff would put them in

²⁹ California Department of Justice, *Open Justice, Arrests* (2021); California Department of Finance, *Estimates, Annual Intercensal Population Estimates by Race/Ethnicity with Age and Gender Detail, 2000-2010 and 1990-1999* (2021).

a safety cell.” *Id.* at 22. We are also aware of recent suicide attempts at the jail.³⁰ Many of these deficiencies have also been raised in federal litigation.³¹

We also learned that the jail lacks adequate discharge planning services and often fails to connect people leaving the jail to community-based services upon release. These services are crucial to avoiding recidivism and future institutionalizations. Indeed, DRC spoke to many individuals and providers who confirmed that people with mental health disabilities regularly cycle in and out of the County’s institutions and jails due to a lack of community services and continuity of care. *Id.* at 22-23.

The County’s jailing practices and its failure to provide appropriate services discriminates against people with disabilities, “increase[ing] the risk of mental health decompensation” and the likelihood that a person will be institutionalized or arrested again after release. *See id.* at 23. As a result, the County’s current system puts people at serious risk of institutionalization and conflicts with the ADA. *Cf. U.S. v. Miss.*, 400 F. Supp. 3d 546, 555, 576-77 (S.D. Miss. 2019) (finding that “cycling admissions” through psychiatric institutions are “the hallmark of a failed system” and ruling that expansion of community-based crisis services was required by the ADA); Statement of Interest of the United States, *M.G. v. Cuomo*, No. 19 Civ. 639 (S.D.N.Y. Feb. 12, 2021) (supporting class action by people with mental illness alleging that they face a serious risk of institutionalization upon release from prison due to New York’s failure to provide community-based mental health housing and supportive services in violation of the ADA), <https://www.justice.gov/crt/case/mg-v-cuomo>; *Kenneth R. v. Hassan*, 293 F.R.D. 254, 271-72 (D.N.H. 2013) (affirming class certification in *Olmstead* case involving individuals at risk of institutionalization due to multiple hospitalizations, emergency department admissions, criminal justice involvement, and lack of community services).

B. The County Lacks Key Service Components Required by the Medicaid Act, Including Community-Based Crisis Intervention, Crisis Stabilization, and Crisis Residential Services.

Under the Medicaid Act and related law, Tulare County is responsible for directly providing, or arranging and paying for the provision of, Medi-Cal specialty mental health services, including Crisis Intervention, Crisis Stabilization, and Crisis Residential

³⁰ *Sheyanne N. Romero*, Tulare County inmate found dead in jail cell, deputies suspect suicide, *Visalia Times Delta* (Dec. 24, 2020), <https://www.visaliatimesdelta.com/story/news/2020/12/24/tulare-county-inmate-found-dead-jailcell-deputies-suspect-suicide/4044377001>.

³¹ *Criswell v. Boudreaux*, Case No. 1:20-cv-01048 (E.D. Cal).

Treatment services,³² which are intended to provide brief therapeutic interventions to help relieve and resolve crises in the community, while also reducing the risk of hospitalization and law enforcement involvement.³³ The County is obligated to ensure that specialty mental health services “are adequate to meet the needs” of beneficiaries. Cal. Code Regs., tit. 9, § 1810.345.

In addition, the Medicaid Act requires the County to ensure that eligible individuals are provided specialty mental health services, including crisis services, with “reasonable promptness.” 42 U.S.C. § 1396a(a)(8). The County must also ensure that, “[e]ach service [is] sufficient in amount, duration, and scope to reasonably achieve its purpose,” 42 C.F.R. § 440.230(b); see 42 U.S.C. § 1396a(a)(10)(B), and that benefits are provided in equal “amount, duration and scope,” to all categorically and medically needy Medicaid beneficiaries. 42 U.S.C. § 1396a(a)(10)(B)(ii); 42 C.F.R. § 440.240. These regulations require that Medicaid beneficiaries receive sufficient and meaningful services that are comparable to the benefits available to beneficiaries in other counties.

Tulare County’s current crisis services and treatment modalities conflict with these Medicaid laws and regulations. For example, the County’s singular focus on providing legal evaluations for involuntary treatment fails to provide required therapeutic interventions to help relieve or resolve a crisis in the community and reduce the risk of hospitalization and police involvement. Madenwald Report 12-16, 19-21. Involuntary detentions are legal processes that are wholly separate and apart from the therapeutic Crisis Intervention services that must be available to Medi-Cal beneficiaries as a specialty mental health service, and which the County fails to provide. Ms. Madewald’s report details how these teams provide assessments, and often leave without offering further treatment if they conclude the person does not meet criteria.

Medicaid beneficiaries with urgent mental health needs face lengthy delays to access services, if they are able to obtain them at all.³⁴ As noted above, our investigation showed the PET is understaffed and seldom responds to crises in the community. The County’s failure to provide sufficient community-based crises services puts Medicaid beneficiaries at risk of decompensation, a law enforcement response, and/or involuntary detention.

Our investigation also found that Crisis Stabilization and Crisis Residential Treatment service components are largely missing from Tulare County’s crisis system, even though they are covered specialty mental health services required by Medicaid

³² These Medi-Cal services are defined at *supra* n.13-15 and are discussed in Ms. Madenwald’s report at pages 5-8. These services are intended to provide brief therapeutic interventions to resolve crises in the community and reduce hospitalization and law enforcement involvement.

³³ See Centers for Medicare and Medicaid Services, *Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services* (December 28, 2021), www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf at 2.

³⁴ See *supra*, pp. 6-8, discussing PET’s lack of community-based Crisis Intervention services.

law. In our interviews, nearly all providers confirmed the need for these services, and discussed the overreliance on involuntary hospitalization that is a consequence of the County's failure to provide these services.

These deficiencies in the County's crisis service system are inconsistent with Medicaid laws and regulations and leave beneficiaries without medically necessary services for which the County is statutorily and contractually responsible.

II. To Comply with State and Federal Law, the County Must Take Immediate Steps to Reasonably Modify its Existing Crisis System and Expand Community-Based Crisis Services.

Our investigation found that the need for community-based mental health treatment in Tulare County greatly outpaces the County's current capacity to provide such services, even given recent efforts to fund some additional community programs. Providers at virtually every facility we visited spoke about how the lack of adequate community-based mental health and crisis stabilization services create significant barriers to providing County residents with safe environments and opportunities for recovery. We also found that, despite its shockingly high arrest, jailing, and mental health case-load rates, neither the Sheriff nor the Probation Department provide meaningful early-intercept criminal-system diversion programs, which are designed to divert people with mental health disabilities away from the criminal system.³⁵ Such programs provide interventions at the point of arrest or booking that divert people to services in the community in lieu of criminal-system involvement.³⁶

To comply with state and federal law, the County must take immediate steps to cease the unnecessary institutionalization of people with disabilities and reasonably modify its system by expanding culturally responsive and trauma-informed community-based crisis services, including by implementing the recommendations set forth in Ms. Madenwald's Report. See *Townsend*, 328 F.3d at 517 (expansion of services from

³⁵ Although the Probation Department offers community supervision programs such as Field Supervision, which includes connections to mental health and social services, and Readiness for Employment through Sustainable Education and Training (RESET), such programs are only available after a person becomes justice-involved. See Tulare County Probation Dep't, Adult Division (2022), available at <https://tularecoprobation.org/divisions/adult-division/>.

³⁶ One example of this is the CARES Navigation Center in Alameda County, which provides an avenue for law enforcement agencies to connect people with mental health disabilities to community services instead of taking them to jail. Services include peer support specialists, assessment by a mental health clinician, and connection to community-based mental health and social services. See Alameda County, CARES Navigation Center, https://www.alcoda.org/newsroom/2021/jul/cares_navigation_center. This differs in important ways from specialty courts such as the County's Mental Health Court, which is a post-booking program that imposes sanctions for non-compliance with a court-ordered treatment plan. Such programs do not protect participants from the clinical and social harms associated with criminal justice involvement and are not consistently effective in preventing recidivism.

institutional to community settings required by the ADA); *Mississippi*, 400 F. Supp. 3d at 548, 576-77 (same). As Ms. Madenwald concluded, “to meet minimum standards,” the County’s services must be “designed to resolve crises in the community and minimize the need for treatment in institutional settings, particularly on an involuntary basis.” Madenwald Report 15.

As noted above, DRC intends to seek implementation of all of Ms. Madenwald’s recommendations in order to achieve Tulare-County-specific resolution of the issues described herein. Although we are prepared to pursue judicial remedies, we seek to work with the County through a structured and collaborative resolution process. To further that goal, we have prioritized below three key remedial measures that, if implemented, would make great strides toward remedying the legal violations identified above. The County Health and Human Services Agency and the Sheriff should cooperate to develop the following services, which are presently missing or inadequately available:

- Meaningful Crisis Intervention services, separate from PET, designed to de-escalate and resolve mental health crises in the community without law enforcement involvement or the need for institutional care;³⁷
- Voluntary, community-based, peer-led Crisis Treatment services that provide short-term alternatives to institutional care for crises that cannot be immediately resolved in the community;³⁸ and
- Early-intercept criminal-system diversion programs, designed to divert people with mental health disabilities away from jail and to behavioral health services before or immediately after arrest.³⁹

As explained by Ms. Madenwald, this is a solvable problem. Tulare County already has the framework of a crisis system that could prevent unnecessary institutionalization of people with mental health disabilities, but has not sufficiently developed community-based components that would make meaningful crisis services a reality. DRC looks forward to working with the County to implement remedial measures that will bring the County into compliance with state and federal law.

³⁷ See Recommendations Two, Five, and Seven in Ms. Madenwald’s Report. Madenwald Report 28-29, 30, 32-33.

³⁸ See Recommendations Four and Seven in Ms. Madenwald’s Report. *Id.* at 30, 32-33.

³⁹ See Recommendations Six and Seven in Ms. Madenwald’s Report. *Id.* at 31-33.

III. Conclusion

Please let us know when you are available for a meeting to discuss the findings and recommendations in this letter. We request that you respond no later than August 26, 2022, so that we may find a time that works for DRC and the County. In addition, if you have any questions regarding our findings or recommendations, please do not hesitate to contact us. Thank you again for your ongoing cooperation and courtesy.

Sincerely,



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Encl: Madenwald Report (Attachment A)

Cc: Jennifer M. Flores, Eric Scott, Tulare County Counsel's Office

Attachment A

**ASSESSMENT OF TULARE COUNTY
BEHAVIORAL HEALTH CRISIS SERVICES**



June 2022

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INTRODUCTION

Disability Rights California (DRC) asked me, Kappy Madenwald, to evaluate Tulare County's system of providing care to individuals experiencing behavioral health crises, and to offer my opinions regarding whether the County's system meets minimum standards. This report sets forth my opinion that Tulare County fails to meet minimum standards for crisis services and makes recommendations for systemic improvements to meet those standards. After describing my qualifications and methods, the report provides a summary of my opinions; sets forth my opinion of the minimum standards for crisis services; explains my opinions relating to Tulare County's failure to meet minimum standards; and, lastly, sets forth my recommendations.

QUALIFICATIONS

I have twenty years of experience delivering or supervising mental health services in a variety of settings, including hospital inpatient units, emergency departments, crisis centers, and community settings. I am licensed in the State of Ohio as an Independent Social Worker with a Supervisor Credential (LISW-S). My Curriculum Vitae is included as Attachment 1.

From 1996-2005, I oversaw mental health crisis services in Franklin County, Ohio, including as Manager of the Children's Mobile Crisis Team and Clinical Director of the County's chief provider of adult crisis services. As Clinical Director, I oversaw the provision of services to approximately 30,000 people/year, including through mobile, walk-in and bed-based crisis programs. I worked with emergency departments and inpatient units, state hospitals, community mental health centers, and Assertive Community Treatment (ACT) and specialty teams to reduce reliance on hospitals for crisis care and to coordinate continuity of care following crisis events. From 2005-2007, I served as the first Clinical Director at the Franklin County Alcohol, Drug and Mental Health Board. I oversaw six community mental health centers and helped reduce the number of people using crisis services, decrease state-hospital bed usage, and overcome barriers to discharge from mental health facilities, including housing barriers.

Since 2007, I have served as a consultant for the development, delivery, and/or evaluation of behavioral health services through my consulting firm, Madenwald Consulting, LLC. I have provided consultation services in twenty-one states and in Ontario, Canada, primarily at the request of federal, state, or local government agencies, insurance companies, or treatment providers. I have had significant involvement in several lawsuits due to my expertise on mental health services, including crisis services. I was a consultant to the court monitor in *Rosie D. v. Patrick*, 01-30199 (D. Mass.), a federal class action lawsuit involving Massachusetts' inadequate provision of Medicaid services for children with serious emotional disturbances, and subsequently served as a consultant to all of the parties. I also provided extensive training and coaching to the teams selected to provide mobile crisis services to children and families. In *United States v. Mississippi*, 16-00622 (S.D. Miss.), a case brought by the United States alleging that Mississippi's mental health system violated the Americans with Disabilities Act and related laws, I was engaged by the Department of Justice as an expert on adult mental health services.

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In a case brought by Protection and Advocacy for People with Disabilities, Inc. against the South Carolina Department of Mental Health, *A.W., et al. v. Magill, et al.*, 17-01346 (D.S.C.), I evaluated and wrote an expert opinion on whether defendants unnecessarily segregated people with mental disabilities in institutional settings and whether defendants failed to provide appropriate supports and services that would allow them to live in integrated community settings. I served as a crisis system subject matter expert in the implementation of a United States Department of Justice consent decree with the Baltimore City Police Department in *United States v. Police Dept. of Baltimore City*, 17-00099 (D. Md.). I am also a crisis system subject matter expert in the implementation of a Department of Justice agreement with Louisiana, *United States v. Louisiana*, 18-00608 (M.D. La.). In other matters, I have made myself available to the Department of Justice Civil Rights Division and the Bazelon Center for Mental Health Law as an expert in developing effective community treatment systems, including crisis systems of care.

METHODS

In forming my impressions and opinions as laid out in this report, I reviewed numerous documents relating to Tulare County's behavioral health and criminal justice systems, including many relating to the County's crisis intervention services and mental health programs. Over the course of approximately twelve weeks, I met with dozens of key informants and participated in over ten meetings with County officials and staff, mental health service providers, mental health consumers, and other individuals with local knowledge of practices in Tulare County.

SUMMARY OF OPINIONS AND RECOMMENDATIONS

Based on my review of documents and interviews with key informants, my primary and overarching finding is that Tulare County fails to meet minimum standards¹ for behavioral health crisis services and improperly relies on coercive crisis intervention strategies, institutionalization, and detention. The County relies primarily on its Psychiatric Emergency Team (PET), which has far too few staff and improperly focuses on the involuntary detention of residents being held in emergency departments or the jail for evaluation under California Welfare & Institutions Code (WIC) Sections 5150 and 5585.² PET seldom engages with residents while they are at home or in the community, where crisis intervention would be most effective in stabilizing people in crisis and preventing involuntary hospitalization, arrest, or incarceration. Unfortunately, PET also operates without other essential components of a crisis response system, such as an adequate

¹ In this report, and as described more fully below, "minimum standards" refers to the components and qualities that, in my opinion, represent the minimum requirements of a behavioral health crisis system of care.

² As discussed below, WIC Sections 5150 (for adults) and 5585 (for minors), permit peace officers and county-designated professionals to take an individual into custody and place them in a facility for 72-hour treatment and evaluation. *See* WIC §§ 5150 & 5585 *et. seq.* Under WIC Section 5250, involuntary commitments may be extended up to 14 days, and then beyond that if certain legal criteria are met. *See* WIC §§ 5260, 5270, 5300, and 5350. Unless specifically noted otherwise, references to "legal evaluations," "involuntary commitments," "detentions," or "holds" are intended to include all involuntary psychiatric commitments performed by the County.

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Call Center, Crisis Intervention, and Crisis Treatment Services, as defined below. As a result, the County's mental health system fails to provide crisis services voluntarily, at the right time, and in the right setting.

While there is much work to do, I was encouraged by my discussions with Tulare County leadership, mental health providers, and law enforcement. It is clear that there is a widely held desire among key stakeholders to provide a clinically appropriate menu of options for responding to community members experiencing mental health emergencies. There also appears to be genuine investment in relationship-building and cross-agency collaboration, which is critical to improving crisis services across systems. Tulare County has many opportunities to change the ways in which it delivers mental health crisis response services, thereby reducing the risk of trauma and other treatment-induced harms that result from the way it currently operates.

My opinions regarding Tulare County's crisis services are as follows:

- 1. Tulare County prioritizes legal evaluations for involuntary treatment over meaningful Crisis Intervention.***
- 2. The County provides the overwhelming majority of its crisis services in emergency departments and institutions, rather than in less-restrictive community settings.***
- 3. Tulare County's policy and practice is to provide crisis services on an involuntary basis, even for people seeking treatment voluntarily.***
- 4. Tulare County relies on serial involuntary commitments when a treatment bed is unavailable, disregarding patients' rights and causing unnecessary iatrogenic harm.***
- 5. Tulare County lacks a meaningful Call Center service component with Crisis Intervention and de-escalation services.***
- 6. Tulare County lacks meaningful Crisis Stabilization and Crisis Residential Treatment service components.***
- 7. By design, law enforcement is often the first and only response to crises in the community, creating a significant risk of decompensation, arrest, and incarceration.***
- 8. The County improperly relies on jails to provide mental health treatment to people who could be served in the community.***
- 9. Tulare County's crisis system is characterized by systematic disregard for the individual and the iatrogenic risks of coerced practices and involuntary treatment.***
- 10. Tulare County has made minimal investment in voluntary, community-based crisis services.***

My recommendations to Tulare County are:

- 1. Immediately assess the crisis service system in order to mitigate the misuse of involuntary treatment and coerced care.*
- 2. Create a true Crisis Intervention service that is primary to and separate from the work of PET and involuntary treatment processes.*
- 3. Ensure that all providers of crisis services are trained in essential competencies.*
- 4. Make significant investments in peer-informed and peer-delivered services.*
- 5. Drastically reduce law enforcement involvement in crisis care.*
- 6. Identify early-diversion and -intercept opportunities to reduce the number of people receiving mental health treatment in jails.*
- 7. Make strategic investments in essential components of a crisis system of care.*
- 8. Strengthen data-collection systems and use them to drive improvements to the crisis system on an ongoing basis.*

MINIMUM STANDARDS FOR BEHAVIORAL HEALTH CRISIS SERVICES

Based on my review; my familiarity with, evaluation of, and professional engagement by many crisis systems across the country; and expertise in clinical behavioral health care and crisis services, I have determined that there are minimum standards for behavioral health crisis services. In my opinion, the minimum standards are comprised of *essential components* and *essential qualities*. My opinions as to these minimum standards are aligned with the standards developed by the federal Substance Abuse and Mental Health Services Administration (SAMHSA)³ and the National Association of State Mental Health Program Directors (NASMHPD).⁴ In addition, the California Department of Health Care Services (DHCS) recently published an assessment of the State’s behavioral health continuum of care that endorses these essential components and qualities of a behavioral health crisis system of care.⁵

³ See Substance Abuse and Mental Health Services Administration (SAMHSA), *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* (2020), www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf (hereinafter “SAMHSA Toolkit”).

⁴ See National Association of State Mental Health Program Directors (NASMHPD), *Crisis Services: Meeting Needs, Saving Lives* (August 2020), www.nasmhpd.org/sites/default/files/2020paper1.pdf.

⁵ See State of California Department of Health Care Services, *Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives, and Implications* (January 10, 2022), www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf (hereinafter “DHCS Assessment”).

1. Essential Components of Crisis Care

Effective crisis systems of care are comprehensive and include strategies for crisis prevention, early intervention, acute crisis response, crisis treatment, crisis recovery, and reintegration.

Specific to acute crises, which is the focus of this review, my opinion is that there are three essential components of crisis systems that ensure timely and least restrictive access to appropriate acute crisis response and crisis treatment services. These components include: (1) a 24/7 Crisis Call Center; (2) Crisis Intervention, which may include telephonic support, walk-in urgent care, and mobile crisis services; and (3) Crisis Treatment Services, which may include 23-hour crisis stabilization beds, short-term crisis residential facilities, and sobering centers. This set of services can also include brief, in-community intensive support and stabilization services. Although these components can and should be designed to meet the specific needs of each region, all services should adhere to the standards below.

- i) **Crisis Call Centers** offer 24/7 telephonic services as an alternative to 911 and law enforcement response. Crisis Call Centers have capacity to de-escalate crises through calls, texts, or online chat. Such services should meet National Suicide Prevention Lifeline (NSPL) standards⁶ for risk assessment and engagement of individuals at risk of suicide and effectively coordinate care in real time. Modern Crisis Call Centers can dispatch mobile teams, monitor crisis resources, and maintain transparent data dashboards in real time to optimize crisis-system functioning.
- ii) **Crisis Intervention** Services offer unplanned emergency brief assessment, treatment and support designed to help a person in crisis experience relief quickly, with full resolution whenever possible. Crisis Intervention Services are typically delivered by Mobile Crisis Response Teams and may also be provided through walk-in behavioral health urgent care centers or peer-respite centers.

The primary clinical purpose of Crisis Intervention is to relieve or resolve crises at a person's home, school, workplace, or other location in the community as an alternative when emergency department use is avoidable, thereby diminishing the need for inpatient hospitalization and reducing the need for law enforcement in all aspects of the crisis response. These services are typically provided without placing a person on an involuntary hold.

Crisis Intervention Services must be available 24/7 and have the capacity to respond face-to-face and the flexibility to stay with the person until the crisis subsides or until further services are arranged when indicated. Services should be provided by mobile crisis teams,

⁶ National Suicide Prevention Lifeline, Suicide Risk Assessment Standards (2007), www.suicidepreventionlifeline.org/best-practices.

preferably inclusive of a Peer Specialist,⁷ that meet people in their home or community, or provide services by phone or telemedicine as appropriate.⁸ Alternatively, Crisis Intervention could be provided at walk-in behavioral health urgent-care centers or peer-respite centers. To facilitate a smooth transition for people whose crisis cannot be resolved with a brief intervention, some jurisdictions choose to co-locate walk-in behavioral health urgent-care centers with 23-Hour Crisis Stabilization, described below. In all cases, linkages should be provided to community-based resources for support. This essential component is consistent with California's definition of "Crisis Intervention," and most, if not all, of the Crisis Intervention services described herein could be billed to Medi-Cal for eligible beneficiaries.⁹

iii) **Crisis Treatment Services** include a range of short-term voluntary treatment and stabilization services. Bed-based services are generally provided in home-like, non-hospital environments. Sometimes these services are designed to be accessible on a walk-in basis and sometimes they are accessed by referral from mobile crisis or behavioral health urgent care teams. Crisis Treatment Services should incorporate Peer Specialists and should provide intensive post-crisis follow up and supports in the community to ensure care access and engagement. Below is a sample range of services that could satisfy this essential component.

- **23-Hour Crisis Stabilization** is an unplanned expedited crisis service lasting less than 24 hours to address an urgent condition that cannot be adequately or safely addressed in a community setting. The goal of 23-Hour Crisis Stabilization is to provide a very brief, less-restrictive alternative to inpatient services for individuals who would be at risk of hospitalization if the condition is not treated, including those who present an imminent threat to self or others, or who are at risk of becoming gravely disabled. 23-Hour Crisis Stabilization services should be staffed 24/7 with a multidisciplinary team capable of meeting the needs of individuals served; can be designed to accept walk-in patients and first-responder referrals; should not require medical clearance as a condition of admission; and should be equipped to coordinate connection to ongoing care. 23-Hour

⁷ Peer Specialists are people with lived experience who have had success in the recovery process and who help others experiencing similar situations. Peer Specialists may engage in a wide variety of activities, including "advocacy, linkage to resources, sharing of experience, community and relationship building, group facilitation, skill building, mentoring, goal setting, and more." *See, e.g.,* DHCS Assessment at 49, 88; SAMHSA, Core Competencies for Peer Workers in Behavioral Health Services at 1 (2015), www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies_508_12_13_18.pdf.

⁸ Centers for Medicare and Medicaid Services, *Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services* (December 28, 2021), www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf.

⁹ California's Medi-Cal regulations define "Crisis Intervention" as a service that lasts less than 24 hours for a condition that requires a more timely response than a regularly scheduled visit, may be provided face-to-face or by telephone, and may be provided anywhere in the community. 9 Cal. Code Regs. §§ 1810.209, 1840.336.

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Crisis Stabilization could also potentially provide sobering services and initiate Medication Assisted Treatment (MAT) when indicated. Most services provided as 23-Hour Crisis Stabilization may be billable to Medi-Cal for eligible beneficiaries.¹⁰

- **Crisis Residential Treatment** offers therapeutic or rehabilitative services in small, voluntary, unlocked residential, and often homey settings. These may include crisis apartments or peer-run stabilization programs. These programs vary in size but generally have no fewer than 4 to 6 beds (for reasons of cost efficiency) and no more than 16 beds (in order to be a Medicaid-reimbursable service). The goal of Crisis Residential Treatment is to provide a short-term (2 to 7 days), individualized treatment service as an alternative to hospitalization for people experiencing an acute psychiatric episode or crisis. The service can include a range of activities and services that support people in resolving and recovering from acute crises, improving and/or preserving interpersonal and independent living skills, and accessing meaningful community supports. Crisis Residential Treatment should not be limited to people discharging from psychiatric hospitalizations, but instead should primarily if not exclusively be used to divert people *away* from hospitalization. Crisis Residential Treatment is a California Medi-Cal service.¹¹
- **Sobering Centers** are used to divert individuals from emergency departments and jails when they are publicly intoxicated in a way that puts them at risk, and who require observation and minimal medical support while sobering. Sobering Centers may also provide light engagement, harm reduction, and rapid pathways to treatment services, potentially including MAT.¹² Sobering Centers are an “in lieu of services” benefit available to eligible Medi-Cal Managed Care beneficiaries, effective January 2022.¹³
- **Ambulatory Crisis Stabilization Services** are voluntary, brief, and intensive post-crisis intervention services designed to support a person in the community and in lieu of a bed-based service. These services provide highly individualized safety-planning, problem-solving, multi-system planning, continued crisis support, and rapid efforts to address barriers to whole-health care by a community-based team. Referrals to this type of

¹⁰ California’s Medi-Cal regulations define “Crisis Stabilization” as services lasting less than 24 hours that require a more timely response than a regularly-scheduled visit and that are provided at specially-designated facilities. 9 Cal. Code Regs. §§ 1810.210, 1840.338(a).

¹¹ California’s Medi-Cal regulations define “Crisis Residential” as therapeutic or rehabilitative services provided in a non-institutional residential setting, which provide a structured program as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis. The services must be provided by specially-licensed and certified programs and must include a range of services designed to support recovery. 9 Cal. Code Regs. §§ 1810.248, 1840.334(c), (d).

¹² DHCS Assessment at 91. DHCS reports that Tulare does not have a sobering center. *Id.* at 180.

¹³ State of California Health and Human Services Agency, Department of Health Care Services, *Medi-Cal Community Supports, or In Lieu Of Services (ILOS), Policy Guide* at 50 (June 2022), www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf.

service generally come from mobile crisis or behavioral health urgent care teams. Varying by program, these services are typically provided for up to six weeks and are billed as an outpatient service. There is considerable flexibility here to apply Assertive Community Treatment, Wraparound Care Planning, and Peer Specialist support in this brief crisis treatment service.

2. Essential Qualities of Crisis Care

My opinion is that all crisis services should embody the following essential qualities in order to meet minimum clinical standards. These essential qualities complement the service components described above and will support delivery of localized, voluntary, least-restrictive, resolution-focused, and peer-informed crisis care.

All crisis services must be provided in the least restrictive setting, consistent with a person's preferences and shared goals of recovery and resiliency.¹⁴ When crises are managed in comfortable and familiar settings, people feel less isolated and are better able to manage feelings of frustration, anxiety, panic, and depression. This creates a sense of empowerment and belief in one's recovery and ability to respond to future crises. It gives the responding team a better understanding of a person's lived experiences, challenges, and resources, and also allows ready engagement with others in the home/setting. Providing services in community settings, including at a person's home or other community location, is critical to achieving the clinical goals of building trust in a way that feels psychologically safe, de-escalating and resolving the crisis, and improving future patient engagement, all of which improve long-term health outcomes.

Crisis services must incorporate the core competencies of recovery-oriented, culturally competent, and trauma-informed care. Outmoded models of crisis care seek to address what is "wrong" with the individual. Outmoded models also include efforts by treatment teams to contain perceived risk through restrictive and often through involuntary treatment. In worst-case scenarios, this approach intersects with inadequate crisis care components, such as a lack of voluntary mobile and facility-based crisis services, resulting in people being restrained on emergency room gurneys, involuntarily hospitalized, or transferred to jail due to behavioral manifestations of mental health conditions.¹⁵

¹⁴ SAMHSA Toolkit at 31; NASMHPD, *Crisis Services: Meeting Needs, Saving Lives* at 19. The provision of crisis services in the least restrictive setting is also consistent with the Americans with Disabilities Act, 42 U.S.C. § 12101 *et seq.*; the U.S. Supreme Court's ruling in *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999); and Medi-Cal rules governing the provision of rehabilitative specialty mental health services, *see* California Department of Health Care Services, *Annual Network Certification – Specialty Mental Health Services* at 7 (2021), www.dhcs.ca.gov/Documents/2021-MHP-Network-Certification-Summary-Methodology-and-Findings.pdf.

¹⁵ *See* SAMHSA Toolkit at 27.

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Such practices significantly increase the risk of *iatrogenic harm*¹⁶ to the person in crisis. Of great concern is a situation in which a person chooses not to confide in the treatment provider even when their life is at risk due to fear of forced treatment. This happens *not* due to paranoia or incompetence, but because the treater and the system have not earned their trust. It is a natural and protective instinct.

To meet minimum standards, crisis services must incorporate core competencies that are:¹⁷

- Person-centered and collaborative, rather than expert-driven and/or imposed on the person requesting services;
- Strength-based, rather than pathology/deficit-focused;
- Relief- and recovery-oriented, rather than focused on assessments and referrals;
- Trauma-informed;
- Culturally competent; and
- Engaged with and supportive of family or other support systems.

Trauma-informed care recognizes that the majority of people in crisis have experienced psychological and/or physical trauma, and that people with history of trauma are more likely to be sensitive to how care is provided.¹⁸ Crisis care that involves loss of freedom, noisy and crowded environments and/or the use of force can actually re-traumatize individuals, leading to worsened symptoms and a reluctance to seek help in the future.

Crisis staff should also be equipped to meet the cultural needs of patients and trained in cultural competencies, including cultural humility.¹⁹ The best clinical outcomes result when crisis teams

¹⁶ Iatrogenic harm is harm that is inadvertently caused by medical or mental health treatment or the treatment provider and may include: immediate distress, anxiety, and decompensation; longer-term mental health and reputational harms and stigmatization; familial, financial, academic, employment and housing harms; and lasting harms such as distrust for systems of care and disengagement from treatment, which significantly increase the risk of additional coercive treatment and criminal justice involvement. See, e.g., Ward-Ciesielski, E. F., & Rizvi, S. L., *The potential iatrogenic effects of psychiatric hospitalization for suicidal behavior: A critical review and recommendations for research*, *Clinical Psychology: Science and Practice*, 28(1), 60–71 at 5 (2021), <https://doi.org/10.1111/cpsp.12332>; Murphy, R., et. al, *Service Users' Experiences of Involuntary Hospital Admission Under the Mental Health Act 2001 in the Republic of Ireland*, *Psychiatric Services* 68:1127-1135 (2017), <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201700008>; Rusch, N., et al., *Emotional reactions to involuntary psychiatric hospitalization and stigma-related stress among people with mental illness*, *European Archives of Psychiatry and Clinical Neuroscience*, 264(1), 35–43 (2014). <https://doi.org/10.1007/s00406-013-0412-5>.

¹⁷ See, e.g., SAMHSA Toolkit at 29; SAMHSA, *Practice Guidelines: Core Elements in Responding to Mental Health Crises* at 5-12 (2009), www.store.samhsa.gov/sites/default/files/d7/priv/sma09-4427.pdf.

¹⁸ SAMHSA Toolkit at 29; SAMHSA, *Trauma-Informed Care in Behavioral Health Services* at 11-32 (2014), https://www.ncbi.nlm.nih.gov/books/NBK207201/pdf/Bookshelf_NBK207201.pdf.

¹⁹ SAMHSA, *Practice Guidelines: Core Elements* at 10.

include people with a *similar cultural orientation* as the person being served. Culture-specific Peer Specialists may assist with this by providing cultural bridging during crisis care.

Crisis services must be provided on a voluntary basis to the greatest extent possible, and must not be conflated with legal processes for involuntary treatment. Under WIC Sections 5150 and 5585, peace officers and county-designated professionals may take an individual into custody and place them in an emergency room or other acute treatment setting on an involuntary basis if the person is found to be a danger to themselves or others and/or is gravely disabled, where they may be held for up to 72 hours for evaluation and treatment. Under WIC Section 5250, the involuntary commitment may be extended up to an additional 14 days, and then beyond that if certain legal criteria are met.

To meet minimum standards, involuntary treatment must be held in reserve as a clinical intervention of last resort—as an exception to the general rule of providing voluntary, recovery-oriented, community-based crisis services. This applies even when a person meets the criteria for involuntary commitment if they are willing to accept treatment, and providers have a duty to advise them of their right to do so. A county’s power to treat involuntarily carries tremendous responsibility, and counties must balance the exercise of this power against the rights of individuals to choose their healthcare and live and be in the community.

Crisis Intervention should be provided by specially-trained mental health staff and Peer Specialists.²⁰ Crisis Intervention, including mobile response teams, is preferably provided by a combination of (1) a person with expertise in Crisis Intervention and (2) a trained Peer Specialist with lived behavioral health experience. The use of a Peer Specialist supports clinical engagement efforts through the nuanced insights and strength-based recovery lens that a person with lived experience brings and the unique power of bonding over common experiences.²¹ It also integrates the clinical benefits of peer modeling that recovery is possible.

Interactions with law enforcement should be reduced to the greatest extent possible. Defaulting to 911 and law enforcement as crisis first-responders can actually *exacerbate* crises due to anxiety caused by police vehicles and armed officers, particularly for People of Color and people who are undocumented.²² In addition, a law enforcement response to a mental health crisis increases the risk of involuntary treatment or arrest, often for misdemeanor offenses.²³ These responses fail to meet minimum standards because they do not address the clinical needs of the person in crisis and can cause immediate decompensation and long-term health

²⁰ NASMHPD, *Crisis Services: Meeting Needs, Saving Lives* at 17.

²¹ See, e.g., SAMHSA, *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies* at 13 (2014), www.store.samhsa.gov/sites/default/files/d7/priv/sma14-4848.pdf; Cal. Mental Health Services Authority, *Peer Models and Usage in California Behavioral Health and Primary Care Settings* at 12-14 (2013), www.ibhpartners.org/wp-content/uploads/2015/12/PeerModelsBriefRevFINAL.pdf?utm_source=rss&utm_medium=rss.

²² SAMHSA Toolkit at 33; DHCS Assessment at 113.

²³ DHCS Assessment at 79.

deterioration. Thus, crisis systems must be able to deliver services *in lieu of* law enforcement with the goal of reducing or eliminating law enforcement involvement altogether.²⁴ This standard applies equally to co-responder models that pair law enforcement with mental health staff. Such teams should be deployed only when the use of law enforcement is legally indicated or otherwise unavoidable.

Reliance on jail facilities to provide mental health treatment to people who could be served in the community must be avoided. The reliance on jail facilities for mental health treatment has devastating clinical consequences for people with mental health disabilities. Carceral settings have been shown to worsen mental health—particularly for those incarcerated following a mental health crisis—and can lead to long-term psychiatric and physical harm and cycling in and out of institutions and jails.²⁵ Incarcerated people with mental illness are more likely to be victimized in jail or placed in isolation and seclusion, which carries significant risk of long-term psychiatric harm.²⁶ For many people with mental illness, particularly those jailed for misdemeanor offenses, meaningful Crisis Intervention and community-based mental health services can improve health outcomes and drastically reduce the risk of incarceration.

Crisis service systems should be data-driven and responsive to community needs. Effective crisis systems of care are built on the regular collection and analysis of data, and the use of performance metrics to drive improvements to the system.²⁷ In addition, agencies and systems should view crisis incidents as opportunities to understand and quantify the underlying systemic factors that led to the incident with the goal of preventing reoccurrence and finding long-term solutions. Inter-agency data-sharing and data-review is also essential.

TULARE COUNTY FAILS TO MEET MINIMUM STANDARDS FOR CRISIS SERVICES

Based on the information I reviewed and the meetings and interviews in which I participated, it is my professional opinion that Tulare County fails to meet minimum standards of crisis care because it relies largely on involuntary legal processes and treats residents in restrictive environments, such as emergency departments, hospitals, and jails. Moreover, the County lacks the essential components and qualities of an effective crisis system, including adequate Call Center, Crisis Intervention, and Crisis Treatment Services. However, as illustrated by my discussion of Recommendations, below, Tulare County has many opportunities to change the ways in which it delivers crisis services and to bring its services in line with minimum standards of care.

²⁴ *Id.*

²⁵ DHCS Assessment at 112.

²⁶ See, e.g., D. Dumont, *et al*, Public Health and the Epidemic of Incarceration, *Annual Review of Public Health* (April 2012), www.ncbi.nlm.nih.gov/pmc/articles/PMC3329888/pdf/nihms369306.pdf; N. Wolff, *et al.*, Rates of Sexual Victimization in Prison for Inmates with and without Mental Disorders, *Psychiatric Services* (August 2007), www.ncbi.nlm.nih.gov/pmc/articles/PMC2811043/pdf/nihms168251.pdf.

²⁷ SAMHSA Toolkit at 51.

1. Tulare County prioritizes legal evaluations for involuntary treatment over meaningful Crisis Intervention.

Based on my review of Tulare County's crisis services, it is my opinion that the County does not provide meaningful Crisis Intervention services. Instead, the primary function of the County's crisis system, including PET services, is to assess whether a person in crisis may legally be held against their will for unwanted psychiatric treatment, considering the level of risk presented and the person's ability to follow a safety plan. Although the County designates PET services as "Crisis Intervention," in practice, the County lacks the essential components and qualities of resolution-focused, brief treatment Crisis Intervention, as defined above.²⁸

Meaningful Crisis Intervention must be provided as the first response to a crisis, separate and apart from the legal evaluations and risk analyses that the County is performing. Although evaluation for involuntary commitment may be needed in some cases, it should be reserved as a process of last resort to be used *only* when: (1) the risk to self and others does not abate after Crisis Intervention has been meaningfully and appropriately provided; (2) WIC 5150 or 5585 legal criteria is met; and (3) meaningful voluntary care has been offered and the person refuses to accept it.

This is clearly not what occurs in Tulare County. During my meetings with the County, staff explained PET's role as follows:

Our role in the end, we are the final determiner of 5150 criteria and if it is met. We will uphold or rescind the 5150 in the emergency room.

We are evaluating consumers to determine if they are in crisis to the point where they require a 5150. There are specific criteria to be met.

The County employs this binary thinking about whether or not a person meets WIC legal criteria from the time it first receives a crisis call, and uses it to determine whether PET should respond in person. As explained by staff:

The primary reason for a PET response is to look at suicidality, homicidality and whether the person is grossly decompensated. Those are the crises that require a face-to-face-response.

The County's training materials provided to PET staff also focus primarily on the criteria and processes for involuntary treatment in emergency rooms, hospitals, and jails. The following are examples of PET program training slides that were provided to DRC in response to a request for County crisis-service training materials and are illustrative of PET's function:

²⁸ See discussion of Crisis Intervention services, *supra*.

Examples of PET Program Training Slides

CONSIDERATIONS FOR 5150 DECISION

Danger to Self

- Severity of precipitating action
- Severity of current S/I threats
- Previous attempts
 - Severity of previous attempts
- Homeless
- Lives alone
- Caregiver/Significant other
 - Not available to monitor
 - Feels cannot monitor
 - Will not allow consumer to return home
- Consumer will not participate in safety plan
- Current drug/alcohol use

ASSESSMENT PROCESS

- Obtain background information
 - Speak to Social Worker
 - Read all Doctor and Nurse notes
 - Read the 5150 hold if one has already been written
 - Speak to Psych tech who has been monitoring consumer
- Speak with consumer
 - Ask family/friends to leave room
 - **Always** have consumer sign the financial form
 - Ask for permission to speak with family/friends after assessment
 - If person is not accompanied by family/friends get phone numbers
 - It may be necessary to speak with family/friends without permission (Confidentiality is waived in crisis situations)
 - Does Consumer meet criteria for 5150
 - Can a safety plan prevent hospitalization?
 - Will consumer commit to participate in a safety plan

ASSESSMENT PROCESS

- Consumer Cleared for release
 - KDDH - Place Confidential form in box in zone 4 (North-east corner of ER)
 - Sierra View - Place Confidential form on clipboard with notes and labs
 - Tulare Adventist - Place Confidential form on clipboard with notes and labs
- Consumer held on 5150
 - KDDH - Give 5150 to Social Worker, KDDH will find placement
 - Sierra View - PET finds placement, Make a clear copy of 5150, Place original on clipboard
 - Tulare Adventist - PET finds placement, Make a clear copy of 5150, Place original on clipboard

FILLING OUT THE 5150

- Always use the most current 5150 form
 - 5150 is a legal document not a clinical document
 - Always use black ink or type.
 - Always write legibly
- Detainment Advisement Section
 - Fill out section "My name is..." writing the first and last name of the person who provided the advisement.
 - Check box indicating if Advisement Complete or Incomplete.
 - If "Advisement Incomplete", indicate reason under "Good Cause for Incomplete Advisement" - One sentence is sufficient

PET AOD PROTOCOL

An individual who is under the influence of alcohol or other substance may meet criteria for being DTS, DTO or GD and be intoxicated as a result of using alcohol and drugs as a coping mechanism.

An individual who is under the influence of alcohol or other substance may meet criteria for being DTS, DTO or GD due to their intoxicated state. They may not meet criteria once sober.

STRATEGIES

The level of intoxication renders a crisis evaluation difficult or unfeasible

Field evaluation

- Write 5150 hold, transport to hospital with instructions to hospital that consumer will be re-evaluated When sober.
- Hospital to call PET when consumer ready for re-evaluation.

Hospital evaluation

- Advise hospital that consumer will be re-evaluated when sober. Hospital to call PET when consumer ready for re-evaluation.

PET JAIL RESPONSE PROTOCOL ADULT & JUVENILE

Obtaining a hospital bed for an inmate who meets criteria

- PET will complete a 5150 if inmate/youth meets criteria (DTS, DTO, GD)
- PET member will contact KWD MH to check for placement at a LPS-designated facility
- Inmate/youth will remain in custody and continue to receive mental health and health services from Wellpath until a bed is located. And inmate accepted by hospital
- PET member will send an email to Wellpath clinician, KWD PAT, KWD PAT Manager, and TC PET Manager & Supervisor to update everyone on securing a bed for the inmate/youth.
- PET member will continue to check for beds daily at KWD MH until a bed is located

The County's prioritization of involuntary treatment over meaningful Crisis Intervention "is not a valid approach to addressing a mental health crisis" and, in many cases, "may do more harm than good."²⁹ An evaluation for involuntary treatment is *not* a proxy for whether a person received meaningful care or experienced resolution of the crisis state and symptoms, nor can it tell us whether there has been a reduction of risk to the individual or others. In fact, the threat of involuntary treatment can actually escalate the crisis and cause the person to feel unsafe

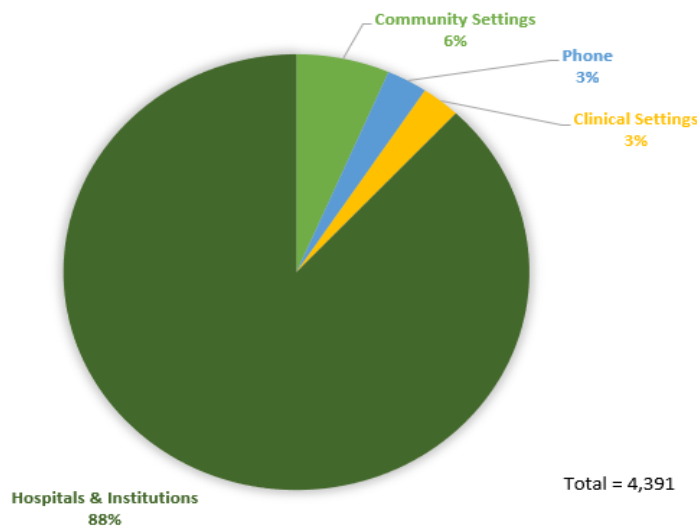
²⁹ SAMHSA, *Practice Guidelines: Core Elements in Responding to Mental Health Crises* at 3 (2009) www.store.samhsa.gov/sites/default/files/d7/priv/sma09-4427.pdf.

disclosing symptoms, thoughts, and feelings that might be life-threatening, leaving PET unable to make informed clinical determinations about the nature of the crisis and a person’s healthcare needs. The threat of involuntary treatment can also destroy a person’s trust in the healthcare system, causing them to avoid future care and/or be labeled as “treatment-resistant”³⁰ by providers. All of these options create a significant risk of clinical harm to the person being served, including a significant risk that the person could be institutionalized or jailed due to the harmful effects of the County’s current treatment modalities.

2. The County provides the overwhelming majority of its crisis services in emergency departments and institutions, rather than in less-restrictive community settings.

Although the County describes PET as a mobile crisis unit that is “able to respond to psychiatric emergencies throughout Tulare County,”³¹ it is my opinion that, in practice, PET functions as an arm of the region’s institutions. Data provided by the County shows that PET logged a total of 4,391 “crisis intervention” contacts in 2020.³² Of those, 88% were delivered in an emergency department, hospital, or jail. Only 6% of PET contacts were in community settings, with the remaining 6% provided in clinical settings (e.g., County mental health clinics) or via telephone.

PET CRISIS INTERVENTION LOCATIONS - 2020



³⁰ “Treatment-resistant,” “treatment non-compliant,” and “service-resistant” are terms that government agencies often use to refer to individuals who avoid or who do not fully engage in offered services. This term and way of thinking fails to account for the various valid reasons a person may avoid services, including that the services offered are not clinically appropriate for the individual, are not experienced as effective, that the services have caused or carry risk of iatrogenic harm, and/or that the service does not account for a person’s trauma experience, including from prior experiences with the service system.

³¹ See, e.g., Tulare County HHSA, Psychiatric Emergency Team General Program.

³² Data provided by the County showed all PET contacts for 2020, sorted by service codes.

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Based on my interviews and review of County documents, PET services in the emergency department are typically provided to people who “walk in” or are “brought in by police,” in which case there is “generally a 5150 written by police.”³³ This means that PET may not see a person in crisis until they have already had contact with law enforcement, ambulance, emergency medical services, and/or emergency department staff, who may have performed medical clearance or treatment.

These are coercive, lengthy practices that the County provides as its response of first resort. By subjecting people in crisis to multiple contacts with law enforcement and/or medical staff before they see a mental health professional, the County adds unnecessary layers of fear and anxiety to its service. This in turn risks exacerbating the person’s initial crisis and increases the likelihood that PET will determine that involuntary treatment is necessary, putting the individual at risk of hospitalization when less-coercive community-based Crisis Intervention modalities could be effective. In addition, people who are treated in emergency departments report experiencing increased distress and worsening symptoms due to noise and crowding, limited privacy in the triage area, and being attended to by emergency room staff who often have little experience with psychiatric emergency care.³⁴ The County’s practices are contrary to minimum standards and carry significant risk that people being served will suffer iatrogenic harm.³⁵

By limiting its crisis services to legal evaluations in institutional settings, the County also fails to provide services in sufficient amount, duration, and scope to deliver effective crisis services and meaningfully respond to people’s needs. Only a fraction of real-life crises result in serious harm to self or others. A response that is activated only when physical safety becomes an issue leaves countless others suffering without any crisis services at all.³⁶ The County’s failure to provide meaningful Crisis Intervention services increases the risk that a person with a mental health disability will experience a law enforcement response, arrest, or incarceration. To meet minimum standards, the County’s services must be designed to resolve crises in the community and minimize the need for treatment in institutional settings, particularly on an involuntary basis. PET by and large is not designed to and does not accomplish these healthcare objectives.

³³ See, e.g., PET Training Presentation, Slide 4.

³⁴ SAMHSA Toolkit at 23; Major, D., et. al, *Exploring the experience of boarded psychiatric patients in adult emergency departments*, 21 BMC Psychiatry 473 (2021).

³⁵ See Ward-Ciesielski, *The potential iatrogenic effects of psychiatric hospitalization for suicidal behavior: A critical review and recommendations for research*, Clinical Psychology: Science and Practice, 28(1), 60–71 at 5 (2021); Murphy, R., *Service Users’ Experiences of Involuntary Hospital Admission Under the Mental Health Act 2001 in the Republic of Ireland*, 68:1127-1135 (2017); Rusch, N., *Emotional reactions to involuntary psychiatric hospitalization and stigma-related stress among people with mental illness*, 264(1), 35–43 (2014).

³⁶ SAMHSA, *Practice Guidelines: Core Elements in Responding to Mental Health Crises* at 3 (2009) www.store.samhsa.gov/sites/default/files/d7/priv/sma09-4427.pdf.

3. Tulare County’s policy and practice is to provide crisis services on an involuntary basis, even for people seeking treatment voluntarily.

Based on my review, it is my opinion that, with rare exception, Tulare County’s policy and practice is to provide hospitalization for psychiatric crises on an *involuntary* basis, even when a person seeks treatment voluntarily. It is my opinion that this practice fails to meet minimum standards, which provide that a person must always have the option to receive treatment voluntarily.

In my interviews, County staff and providers explained that a person hospitalized for psychiatric treatment in the County will nearly always be hospitalized involuntarily—and will “always” be hospitalized involuntarily if the person is Medi-Cal insured.³⁷ In fact, it is explicit written policy at Kaweah Health Mental Health Hospital—the County’s contracted inpatient mental health hospital—that Medi-Cal patients must be admitted involuntarily:

*All Counties in which we are contracted with will utilize the unit to admit clients on an involuntary (5150) status based on the criteria of danger to self, danger to others, or gravely disabled. However, private pay or managed care clients may request voluntary admission.*³⁸

The County’s policy and practices have far reaching consequences in Tulare County, where 41.7% of residents are on Medi-Cal.³⁹ The policy also creates unnecessary barriers to care, risks stigmatization, and curtails basic civil rights,⁴⁰ as illustrated by the following experience of one County resident I interviewed:

The person went to the emergency department *on their own volition* seeking psychiatric treatment. When they arrived, they were told that their only option was to be admitted involuntarily. The patient agreed and a 5150 hold was written. Throughout the hospital stay, the person was actively participating in treatment and continued to express a willingness to do so on a voluntary basis. Asked if they had been given any information about their legal rights, they explained that they had not, though they reported hearing another patient talking about court.

³⁷ This is consistent with the County documents and training materials discussed above, which demonstrate the County’s expectation that psychiatric hospitalizations be processed pursuant to WIC legal criteria for involuntary treatment. *See, e.g.*, PET Training Presentation, Slides 1-4 and discussion, *supra*.

³⁸ Kaweah Health Mental Health Hospital, Unit-Based Plan for Patient Care.

³⁹ Data USA: Tulare County (last visited Feb. 24, 2022), www.datausa.io/profile/geo/tulare-county-ca#health.

⁴⁰ SAMHSA, *Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice*, at 30 (2019), www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care.pdf.

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It is my opinion that, to meet minimum standards of care, the County must cease its policy and practice of providing services involuntarily, and instead develop a policy that preserves the right of individuals to receive services on a voluntary basis.⁴¹

4. Tulare County relies on serial involuntary commitments when a treatment bed is unavailable, disregarding patients' rights and causing unnecessary iatrogenic harm.

During my interviews, County and hospital staff explained that Tulare County's practice is to place individuals on successive involuntary holds if the County determines that discharge or transfer to an inpatient hospital is not feasible within 72 hours.⁴² Although the County informed me that it does not keep statistics on how often people are placed on serial involuntary holds, PET staff estimated that they reevaluate at least one or two people per day whose 5150s are about to expire. County Mental Health leadership explained the practice as follows:

If [a] person sitting in the ED can't be [admitted to a hospital or other placement] and it's been over 72 hours, we will re-evaluate for a 5150.... A person may be sitting in the ED on multiple [5150] applications while we try to find placement.

In addition, during my interviews, County Mental Health leadership explained its practice of calculating the duration of a person's involuntary hold starting from the time the person is transferred from an emergency department and admitted to an inpatient unit. As stated by the County:

A person is not technically on a 5150 until a psychiatrist has admitted them.

Based on my assessment and review, it is my opinion that these County practices are the result of a confluence of factors, including a lack of Crisis Intervention and Crisis Treatment Services and inadequate community-based mental health services, all of which lead many patients to languish in the County's emergency departments for longer than 72 hours. It is also my opinion that the County's practice of holding people in emergency departments on serial involuntary holds, and of discounting the time a person spends there, fails to meet minimum standards of care and risks significant iatrogenic harm. Emergency departments are not intended for multi-day stays and most are unequipped to provide appropriate treatment modalities to people in acute psychiatric

⁴¹ This standard is consistent with Medicaid reimbursement rules, which provide that reimbursement is not conditioned upon involuntary admission, 9 Cal. Code Regs. §§ 1820.200(d), 1820.205, and 1820.225, and California law preventing hospitals from requiring an involuntary hold as a condition of transfer, Cal. Health & Safety Code § 1317(f).

⁴² In California, only certain designated inpatient facilities are authorized to hold people for involuntary psychiatric treatment under the Lanterman-Petris-Short (LPS) Act. Therefore, if a person on a 5150 is in a non-designated emergency department, an effort must be made to place them elsewhere. No emergency departments in Tulare County are designated to hold and treat people on involuntary psychiatric holds under the LPS Act. Therefore, they should all be transferring people on 5150s out of them as soon as possible, either with referrals to community-based services or inpatient treatment for those who require it.

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crisis. Based on my review, many emergency departments, such as the one at Sierra View Medical Center, do not have mental health clinical staff or a designated area for mental health patients. Although the Kaweah Health emergency department has a designated area and mental health clinicians, this area is regularly full, causing patients to be placed in overflow areas. As discussed above, the chaotic, loud, crowded nature of emergency departments means that longer stays will be associated with increased immediate and longer-term iatrogenic harm, including the potential loss of work and housing, and interpersonal or familial challenges.

The County's practice is particularly harmful to people with complex health needs and minors, for whom County providers report a lack of appropriate alternative placement options. These vulnerable populations may be involuntarily held for even lengthier periods of time if they are unable to be safely discharged home or to an alternative community placement.

In addition, it is unclear from my interviews whether people held in emergency departments are provided with appropriate information about their legal rights and contact information for the County's Patients' Rights Advocate. By holding individuals on serial involuntary holds and discounting their time in the emergency department, the County may significantly delay a person's right to independent review of the involuntary hold. A lack of information about rights and options is also likely to increase feelings of distrust, trauma, and other iatrogenic harm.

5. Tulare County lacks a meaningful Call Center service component with Crisis Intervention and de-escalation services.

A positive component of the County's crisis system is the availability of a 24/7 call center taking crisis calls. The County contracts with third-party entity Kings View Corporation to operate a toll-free 24/7 "Access Line," which acts as the first point of contact for callers to the County's 1-800-320-1616 telephone number.⁴³ The Access Line is answered by staff who are trained by the National Suicide Prevention Lifeline (NSPL).

Unfortunately, based on the records that I reviewed and interviews with stakeholders, I believe that it is County policy to divert psychiatric crisis calls *away* from the Access Line and to transfer them directly to PET when Access Line staff identifies such calls. This policy deprives callers of the chance to receive telephonic Crisis Intervention support by NSPL-trained and certified staff. This type of telephonic support is often sufficiently relieving and harm reducing for individuals. Indeed, only 2% of calls to California-based NSPL lifelines result in a referral to law enforcement.⁴⁴ This is a missed opportunity for County residents to receive a less-restrictive crisis service that would decrease the likelihood of institution-based and involuntary treatment.

⁴³ Each County in California is required to provide a 24/7 Beneficiary Access Line to provide information about mental health services. See 9 Cal. Code Regs. § 1810.405(d).

⁴⁴ California and the National Suicide Prevention Lifeline (2020), www.suicidepreventionlifeline.org/wp-content/uploads/2021/06/California-Annual-State-Report-2020.pdf.

6. Tulare County lacks meaningful Crisis Stabilization and Crisis Residential Treatment service components.

Based on my review, it is my opinion that the County lacks adequate Crisis Stabilization and Crisis Residential Treatment Services. According to DHCS, there are no Crisis Stabilization or Crisis Residential Treatment facilities in Tulare County.⁴⁵ Yet DHCS's recent assessment of crisis services found that Tulare County needs a minimum of 22 crisis stabilization slots.⁴⁶ This need was confirmed in multiple interviews with County and provider staff, who described a dearth of options for patients in need of a safe place to receive crisis services and who identified Crisis Stabilization as an essential missing service component. Without these core components, many residents are treated in unnecessarily restrictive care settings, such as emergency departments and jails, and are subject to unreasonable delays to access crisis services. Research has shown that individuals in crisis prefer going to a calming, safe place where they can speak with peers and trained professionals who understand their experiences, and where their healthcare choices are heard and respected. In such alternative settings, the County will be better equipped to de-escalate crises and avoid unnecessary hospitalizations.

7. By design, law enforcement is often the first and only response to crises in the community, creating a significant risk of decompensation, arrest, and incarceration.

Based on my review, it is my opinion that, by design, law enforcement is almost always the first responder to mental health crises in Tulare County communities. During my interviews with County mental health leadership and law enforcement agencies, I was informed that 911 cannot deploy PET. Instead, calls to 911 are dispatched to law enforcement or emergency services, who may then call PET for assistance. However, a comparison of crisis responses shows that PET is involved in only a fraction of community responses. My review of County data shows that PET only responded to community settings on approximately 284 occasions in 2020.⁴⁷ By comparison, the Tulare County Sheriff—whose jurisdiction is generally limited to unincorporated parts of the County—responded to 781 incidents involving WIC 5150 evaluations in 2020 and 670 incidents in 2021.⁴⁸ During our interview, Porterville Police Department estimated that its officers responded to 374 mental health crisis calls in 2021. Tulare

⁴⁵ DHCS Assessment at 195; DHCS, County LPS Designated Outpatient Clinics and CSU at 7 (2021), www.dhcs.ca.gov/provgovpart/Documents/LPS-Outpatient-CSU.pdf; DHCS, Community Residential Treatment System / Social Rehabilitation Program at 11 (2017), www.dhcs.ca.gov/services/MH/Documents/Community_Residential_Treatment_System_Social_Rehabilitation_Program.pdf.

⁴⁶ DHCS Assessment at 203.

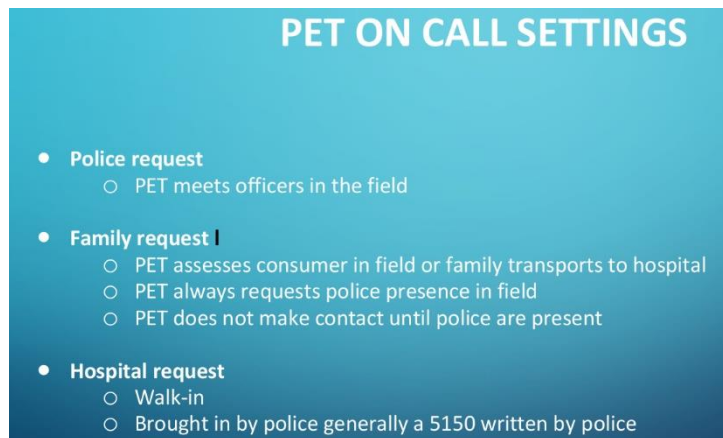
⁴⁷ This finding is based on my review of PET response data for 2020, which was provided by the County.

⁴⁸ This estimate is based on my review of 5150 and mental health response data provided by Tulare County Sheriff for the years 2019 to 2021.

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Police Department estimated that it responded to over 260 mental health calls in 2020.⁴⁹ In the course of my interviews, patients, law enforcement, providers, and County staff explained that the County’s practice is to instruct individuals and police officers to meet PET at the emergency department for evaluation. Depending on the circumstances, law enforcement may transport the person by police car or ambulance, either voluntarily or on an involuntary hold written by the police.⁵⁰

Even when PET does respond in the community, it is County policy for PET to “always request police presence” and not to make contact “until police are present, as illustrated by the following PET training slide:”⁵¹



These County policies and practices fail to meet minimum standards of care because they create barriers to clinically appropriate services and increase the likelihood of arrest, jail, or an involuntary hold. Although local law enforcement agencies have made a commendable effort to train officers responding to mental health crises, officers are not (and do not hold themselves out to be) mental health professionals and are ill-equipped to provide true Crisis Intervention. With limited tools for responding to a mental health crisis, officers often default to routine law enforcement activities that may lead to arrest and iatrogenic harm, such as:

- Running a record check and discovering and enforcing an outstanding warrant;
- Receiving a report of or observing an act that could be criminally charged;
- Deciding to use a “cite and release” charge for a person that is intoxicated;
- Deciding that even if WIC legal criteria are not met, separation of person from home (and perhaps others in the home) is indicated and using any of the previous examples as a way of making that happen; and

⁴⁹ This estimate is based on my review of Mental Health Commitment data produced by Tulare Police Department for the year 2020.

⁵⁰ Based on my review, decisions about the method of transport and whether or not law enforcement writes the involuntary hold can vary widely by agency and individual officers.

⁵¹ PET Training Presentation, Slide 4.

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- Using force, as permissible under agency policy, to detain the person or enforce an involuntary hold, which might include restraint, handcuffs, or other allowable tactics.

For the person in crisis, what was a request for a healthcare intervention becomes a carceral risk that could have been mitigated if Crisis Intervention teams had responded instead. The County's policies and practices on law enforcement involvement fail to meet minimum standards of care.

8. *The County improperly relies on jails to provide mental health treatment to people who could be served in the community.*

Based on my review, it is my opinion that the County improperly relies on jails to provide mental health treatment to residents who could be served in the community. It is also my opinion, based on my interviews and review of records and data, that people with mental health disabilities in Tulare County are being jailed for behaviors relating to mental health disabilities, often on low-level misdemeanor charges or outstanding bench warrants.⁵² This finding is consistent with Tulare County's reported arrest rates, which are more than double the state average,⁵³ and the experiences of County residents. One resident described a "usual" arrest as follows:

They would be off their medications, walking in public and possibly talking to themselves, and someone calls the police. The police arrest them on misdemeanor charges for allegedly being under the influence of drugs. The police take them to jail for short periods of 12-24 hours, after which they are released without services, medications, or resources. They will then miss their court date, which has resulted in multiple warrants and subsequent arrests.

My opinions are also consistent with DHCS's recent assessment, which found that justice-involved Californians have high rates of behavioral health issues and, in fact, are often arrested and incarcerated for behaviors arising from those issues.⁵⁴ These systemic inequalities are compounded for People of Color, particularly for Black, Latino, and Native populations.⁵⁵

My assessment also shows that people with mental health disabilities are disproportionately represented in Tulare County jail. According to the Board of State and Community Corrections,⁵⁶ in September 2021, the average daily population in Tulare County detention

⁵² This finding is based on my review of law enforcement records and incident reports; County Mental Health Court data; publicly reported data; and the experiences of County residents.

⁵³ California Department of Justice, *Open Justice, Arrests* (2021); California Department of Finance, *Estimates, Annual Intercensal Population Estimates by Race/Ethnicity with Age and Gender Detail, 2000-2010 and 1990-1999* (2021).

⁵⁴ DHCS Assessment at 112.

⁵⁵ *Id.* at 113.

⁵⁶ The County submits data to official statewide or national databases maintained by appointed governmental bodies such as BSCC. While every effort is made to review data for accuracy and to

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facilities was 1,286, with 645 people—or 50.2%—on the mental health caseload.⁵⁷ In September 2020, the average daily population was 1,207, with 637 people (52.8%) on the mental health caseload; in September 2019, the average daily population was 1,575, with 761 people (48.3%) on the mental health caseload. Most of this population is likely to be Medi-Cal eligible.⁵⁸

These numbers are exceptionally high. For comparison, the statewide average of counties reporting mental health caseloads for adult populations in September 2021 is only 33%.⁵⁹ For youth, the County’s mental health caseloads are similarly high. In September 2021, 78.6% of the County’s in-custody youth were on the mental health caseload.⁶⁰ As of September 2021, the County’s reported mental health caseload for youth was double the statewide average.⁶¹

There is also concern about the quantity and quality of mental healthcare provided in jail. According to Wellpath, the jail’s mental health provider, people receiving mental healthcare at the jail must be seen at least once a month by a therapist and once every 90 days by a psychiatrist. Although the policy requires daily rounds in segregation and referrals to services for people struggling, incarcerated people report that services are limited to medication, sudoku puzzles, and suicide checks. One Tulare County resident described their experience as follows:

While chronically homeless in Tulare County, they were repeatedly arrested and taken to County jail for minor offenses such as vandalism, and then released to the streets without connection to mental health services. These experiences made them extremely distrustful and afraid of law enforcement. On one occasion, they ran away from homeless outreach officers, and was then arrested for resisting arrest. While in jail, their mental health decompensated due to minimal out-of-cell time and mental health care, and they began to believe that they would die inside the jail. However, they did not ask for help out of fear that jail staff would put them in a safety cell. The mental healthcare they received was limited to medication and checks to see if they were suicidal. Although incarcerated repeatedly in County jail, they never received treatment upon release, and have struggled due to a lack of care.

correct information upon revision, Madenwald Consulting, LLC cannot be responsible for data reporting errors made at the county, state, or national level.

⁵⁷ BSCC Jail Profile Survey (last viewed January 31, 2022), www.bscc.ca.gov/s_fsojailprofilesurvey/.

⁵⁸ DHCS Assessment at 112 (citing California Healthcare Foundation, *From Corrections to Community: Reentry Health Care* (2018), www.chcf.org/project/corrections-community-reentry-health-care/).

⁵⁹ BSCC Jail Profile Survey (last viewed January 31, 2022), www.bscc.ca.gov/s_fsojailprofilesurvey/. Similarly-sized rural counties such as Stanislaus County had a rate of 33% and Solano County had a rate of 27% in 2021. *Id.*

⁶⁰ BSCC Juvenile Detention Survey (last viewed February 24, 2022).

⁶¹ The County reported a caseload of 31.4 per 100,000 population, compared to the state average of 16.4 per 100,000. California Department of Finance, P-2B County Population by Age (last viewed February 24, 2022), www.dof.ca.gov/Forecasting/Demographics/Projections/.

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It is also my opinion that the County's services for people in crisis at the jail, like its crisis services generally, are provided through a coercive, involuntary-treatment-centered approach that fails to meet minimum standards of care. As Wellpath staff explained:

If we have someone in our care who we believe qualifies for 5150, we call PET.

Wellpath staff elaborated that if a person is a "danger to self or others" due to a mental health crisis, jail staff will typically keep the person in custody and keep them "safe" by isolating them in a "safety cell" and/or using a restrictive "green smock" intended to prevent suicide attempts. If staff believes the person is "gravely disabled"—which, according to staff, could include being unable to answer questions, acutely intoxicated, or not oriented to place, time, and situation—staff may call PET to conduct a 5150 evaluation. The number of PET 5150 evaluations inside County adult jails has increased drastically in recent years, from 24 in 2019 to 134 in 2021. Of the PET jail responses in 2021, 50% resulted in 5150 holds.⁶²

When PET writes a 5150 hold, the person will typically remain in jail. As explained by one Wellpath staff member working at the jail:

We are told to keep them and call [PET] in 24 hours for another evaluation. In my experience, they usually stay at the jail because there is no room for them elsewhere.

Based on interviews with the County, PET also evaluates people who have been brought to jail and are "cited and released" within 12 hours. According to County staff:

These are usually for minor offenses, including drug-related behavior. The person might be getting close to the 12-hour limit and if the person isn't stabilized, jail staff will call PET to help with stabilizing the person.

It is my opinion that the County's coercive crisis practices at the jail and its reliance on the jail to house people with mental health disabilities, particularly those incarcerated for misdemeanor offenses, fail to meet minimum standards of care. These practices increase the risk of mental health decompensation; cycling between jails, emergency departments, and homelessness; and repeated arrests and/or 5150 holds. My opinion is consistent with DHCS's recent assessment, which found that people who are justice-involved have a "significantly higher likelihood of ED visits, hospitalizations, and overdose- and SUD-related death."⁶³ Investment in meaningful Crisis Intervention and community-based services can reduce the County's reliance on jails and improve long-term health outcomes for many County residents.

⁶² I reviewed data provided by the County showing PET contacts and 5150 holds at the County jails for the years 2019 to 2021.

⁶³ DHCS Assessment at 113.

9. Tulare County's crisis system is characterized by systematic disregard for the individual and the iatrogenic risks of coerced practices and involuntary treatment.

Based on my review, it is my opinion that the County's crisis system disregards the experience of the individual being served and the iatrogenic risks of the County's practices. This disregard increases the iatrogenic risks of coerced practices and is the principal barrier to remediating the findings discussed herein. The experience of a mental health crisis is psychologically overwhelming. The parts of our brains that manage emotions, including the amygdala, are highly activated during a crisis. We have diminished access to our frontal cortex, which weakens executive function and causes us to feel a loss of control. The amygdala is also triggered when we perceive danger, activating a primal and protective fight, flight, or freeze response. The role of effective crisis response is to create a psychologically safe space and deliver supportive interventions that are calming and de-escalating. In contrast, the County's approach to crisis services risks triggering limbic responses, thus exacerbating the crisis and causing iatrogenic harm.

The County's coercive practices can also have enduring impacts on a person's life and career goals. Placing a person on an involuntary hold creates a permanent medical record. If the episode progresses to a 5250 hold, a legal record is also created. In addition to the social risks of stigmatization and questioning of a person's competency, these records may be used against the person in any number of legal or civil matters—for example, parental fitness in a child custody dispute, or fitness for a particular career⁶⁴—without exploration of whether the involuntary hospitalization was warranted in the first place. As one treatment provider stated:

There are a lot of implications when you write that [5150] hold.

One County resident with a longstanding PTSD diagnosis described the following experience:

When a mental health crisis developed after two major traumatic life events, family members called 911. The police arrived, came into the home, and took the person to the hospital in a police squad on an involuntary hold.

In the emergency room, the person was “strapped to a gurney” and “given involuntary medication” which made them feel “loopy and out of it.” They were then admitted to an inpatient unit for continued treatment. When the person had an altercation with another patient, they were mechanically restrained “for most of the second day” at the hospital and received more involuntary medication. On the third day, staff called a cab and the person was sent home. The person reported that “not a single part of that care was useful. I felt worse than I felt when I went in. I have insecurity about any sort of treatment” going forward.

⁶⁴ For example, involuntary treatment history can also disqualify a person from owning a firearm, which could prevent them from pursuing a career in the military or law enforcement.

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There is an equal question and concern about the crisis care experience of individuals who have been evaluated by PET but who *do not* meet legal criteria for involuntary treatment or for whom involuntary treatment is initiated by law enforcement and rescinded by PET. Not meeting WIC criteria is not synonymous with any existent crisis being “resolved,” and the County’s practices therefore leave many people without appropriate services, putting them at risk of repeat crises, involuntary treatment, and hospitalization.

Throughout my review, it was evident that the County has given little if any consideration to the *care experience* of the person in crisis and the importance of offering services that are experienced as safe and effective. The County policies and training materials that I reviewed do not even mention the iatrogenic risks of coerced treatment, law enforcement involvement, and institutional care. During my interviews, County staff and leadership did not discuss trainings or techniques for recovery-oriented care, such as creating a psychologically safe environment, effective engagement, or shared decision-making.⁶⁵ Although leadership expressed “concern” with the County’s practice of placing people on serial involuntary holds, they did not volunteer awareness of the risks of iatrogenic harm due to that practice, nor did they discuss trainings or practices employed to minimize such practices and risks.

In a system that meets minimum standards, I would expect to see policies and training materials that, at minimum, do the following:

- Promote the creation of safe, community-based environments for crisis intervention;
- Promote effective engagement, trust-building, and shared decision-making;
- Promote person-centered, trauma-informed, and resolution-focused crisis services;
- Identify hospitalization as an intervention of last resort, and requiring that voluntary hospitalizations be offered to all patients; and
- Discuss the risks of and alternatives to hospitalization, including that for some people hospitalization could result in more harm than good.

In Tulare County, these essential attributes are missing in full.

10. Tulare County has made minimal investment in voluntary, community-based crisis services.

Based on interviews with local stakeholders and a review of County budget documents, it is my opinion that Tulare County has made minimal investment in voluntary community-based services. This is reflected in plans underway, which include, for example:

- Implementation of Assisted⁶⁶ Outpatient Treatment (AOT), otherwise known as “Laura’s Law,” which is an involuntary treatment program for individuals who have difficulty maintaining their mental health stability and have frequent hospitalizations and contact

⁶⁵ Shared decision-making involves mutual consideration of person-specific benefits and person-specific iatrogenic risks of hospitalization.

⁶⁶ “Assisted” is a euphemism for “involuntary.”

with law enforcement. In 2021, the Tulare County Board of Supervisors authorized implementing AOT for fiscal year 2021-22.⁶⁷

- Development of new mobile crisis co-responder programs that pair a law enforcement officer and mental health professional to co-respond to crises in the community.⁶⁸

These investments uphold the current system of coercive, law-enforcement-led crisis care. It is only through investment in less-restrictive and resolution-focused crisis services that Tulare County can meet minimum standards.

RECOMMENDATIONS

Changes to the County's crisis services are certainly indicated, and the recommendations below are intended to help align County services with minimum standards and meet the clinical needs of people in crises. As the government entity responsible for oversight, the County must ensure that its crisis services include careful consideration of the rights of the individual, the dignity to choose one's health care, and the freedom to live and be in the community. The good news is that the County exerts significant control over major system components—including the Access Line; crisis services, clinics, Full Service Partnership (FSP) and ACT services; diversion programs; jails; and re-entry services—making it well-positioned to bring the system in line with minimum standards. In addition, County mental health leadership appears open to improvements, and has established collaborative working relationships with local partners, advocacy organizations, hospitals, and law enforcement agencies. The County should continue to build on these relationships to develop meaningful alternatives to the current crisis system. My recommendations for doing so are set forth below.

1. Immediately assess the crisis service system in order to mitigate the misuse of involuntary treatment and coerced care.

I recommend that the County immediately assess its crisis service system in order to mitigate the misuse of 5150/5585 evaluations and coercive care and meet the minimum standards described above. To do this, I recommend that the County engage in a quantitative and qualitative assessment of its crisis services, including an assessment of 5150/5585 utilization and outcomes;⁶⁹ consumer experiences; provider input; and systemic incentives, as described below. The assessment should focus on the following areas:

- The County's prioritization of 5150/5585-evaluation criteria as its primary intervention strategy for people in crisis;
- The County's reliance on law enforcement as a first-response to people in crisis;

⁶⁷ Tulare County, Assisted Outpatient Treatment Program.

⁶⁸ Tulare County Board of Supervisors, Presentation on Co-Response Team.

⁶⁹ I have included recommendations for quantitative data analysis and improving data collection and data sharing in Recommendation Eight, below.

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- The County's policy and practice of providing crisis services primarily in institutions, including emergency departments and jails;
- The County's policy and practice of providing crisis services on an involuntary basis, even for people seeking treatment voluntarily;
- The County's policy and practice of placing people on serial involuntary holds and delaying the time at which the involuntary hold starts for purposes of calculating the duration of the hold; and
- Relying on jail facilities to provide mental health and crisis care to people who could be served in the community.

To assess consumer experiences, I recommend that the County collect data through outreach and engagement and community input/stakeholder meetings. The County's efforts should reach a diverse range of people receiving crisis services, with particular attention to People of Color and the ethnic groups represented in the region. In advance of these efforts, I recommend that the County make crisis service data publicly available, particularly relating to gaps in services, over- and under-utilization of services, and rates of involuntary treatment, arrest, and emergency department usage. The County should seek to collect data about the following types of questions:

For individuals:

- What were your experiences with PET, law enforcement, and time spent in emergency departments on a 5150 hold, including for multiple days?
- What were your experiences with involuntary inpatient treatment?
- How would you describe the health benefits of that stay?
- Did you experience any harm during provision of services or afterwards? (e.g., physical, psychological, emotional harm (like shame), financial, social, or stigma-related)?
- Have these experiences influenced your choice to seek additional mental health services?
- Have these experiences influenced your willingness to share information that may threaten health and safety, including suicidality and homicidality?
- For People of Color, did you experience any race/ethnicity-specific barriers or harms?

For families:

- What was your family's experience before, during, and after receiving crisis services?
- What was your experience if you requested the service and a 5150 was the result?
- For parents of minor children, how did you experience the crisis services?

For people for whom PET determined 5150 criteria were not met:

- Did it feel like you received useful treatment?
- Did you get any relief for the crisis you were experiencing?

To obtain provider input, I also recommend engaging with staff providing crisis care, including PET staff, HHSA FSP and ACT team members, emergency department and hospital staff, and outpatient practitioners. The County should collect and analyze information relating to any held *assumptions* that perpetuate current practices, including beliefs and assumptions about coerced

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care, the benefits of hospitalization, the routine use of law enforcement and 5150s, and legal liability, such as:

- Inpatient treatment is the safest care;
- Inpatient treatment is the highest quality care;
- Inpatient treatment is the best risk management strategy;
- Hospitalizing involuntarily adds extra sense of service provider safety; and
- A sense of inpatient treatment as generally/always good and effective.

Finally, the County should carefully analyze any perverse incentives related to the misuse of involuntary and otherwise coerced care, such as:

- Financial or payor incentives (e.g., payment conditioned on involuntary care);
- Priority access (e.g., priority granted for private insurance versus Medi-Cal or involuntary status versus voluntary status);
- Transportation (e.g., payment incentives related to ambulance transport, or ambulance company reluctance to transport person on voluntary status);
- Convenience (for either the sending or receiving entity); and
- Blanket policies (e.g., requiring that if a person is suicidal in the emergency department, they must be on a 5150).

Upon completion of the assessment, I recommend that the County (1) make its findings publicly available; and (2) hold at least two public meetings in order to incorporate community and stakeholder input into the steps the County is taking to mitigate its practices relating to coercive crisis care, including implementation of the recommendations set forth below.

2. Create a true Crisis Intervention service that is primary to and separate from the work of PET and involuntary treatment.

I have reviewed DHCS's recent assessment, which found that Tulare County must double its Crisis Intervention services in order to meet minimum standards.⁷⁰ To reach this conclusion, DHCS used the Crisis Resource Need Calculator, a tool developed for NASMHPD to estimate optimal crisis system resource allocations for each California county.⁷¹ While DHCS found that the majority of counties had adequate capacity, Tulare County was among the outlier counties with an inadequate mobile crisis system.⁷² DHCS also found that Tulare County had more inpatient beds than needed.⁷³

⁷⁰ DHCS Assessment at 205. The County represented to DHCS that it has two mobile crisis teams.

⁷¹ *Id.* at 80.

⁷² *Id.* at 81.

⁷³ *Id.* at 201.

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I agree with this conclusion and recommend that, within twelve months, the County establish at least two new Crisis Intervention teams led by mental health and Peer Specialist staff that are trained to respond exclusively in the community with limited law enforcement involvement and provide brief, resolution-focused, voluntary treatment. This should be the service of first choice in most instances. Systemic goals include delivering services in the community; increasing the number of individuals who receive this voluntary service as the first—and often the only—face-to-face response to ameliorating the crisis; and reducing the present practice of providing involuntary commitment determinations as a primary response to mental health crises.

The historic role of PET may continue, but should be secondary to the Crisis Intervention teams and used only in exceptional instances in which a 5150 evaluation is unavoidable. Even then, PET should follow the minimum standards described above and work with the person in crisis and the Crisis Intervention team towards consensus decision-making. This approach recognizes the difficulty that some existing staff may experience in giving up the habituated practices and mindsets used in PET's current role of providing 5150 evaluations for involuntary treatment.

Inpatient hospitalization is an important element in the care continuum. And, as a last resort, involuntary treatment can be indicated, but only when:

- Efforts to relieve, resolve, and provide brief treatment have failed (or were contraindicated by the nature of the crisis);
- Efforts to support a person through the course of an acute crisis are not effective;
- Efforts at shared decision-making for voluntary treatment have occurred and there is no consensus;⁷⁴ and
- Less restrictive options for treatment in the community are not available.

Even in these exceptional circumstances when the County treats a person involuntarily, the County should seek to maximize a person's choice and take active steps to mitigate harm.

3. Ensure that all providers of crisis services are trained in essential competencies.

All crisis service providers, including Crisis Intervention teams and PET, must be trained in and practice the following core competencies in order to provide adequate crisis services:

- Person-centered (rather than expert-driven) care;
- Strengths-based (rather than pathology/deficit-focused) care;
- Relief/resolution-focused (rather than assessment/referral focused) care;
- Trauma-informed care as a universal precaution;
- Engaging, supporting and partnering with parents/family members/significant others; and
- Delivering crisis services within the context of the broader crisis system of care.

⁷⁴ As noted above, shared decision-making involves building consensus with the individual about treatment decisions based on mutual consideration of person-specific benefits and person-specific iatrogenic risks of hospitalization.

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Without these core competencies, the County will be unable to create effective alternatives to coerced care and avoid iatrogenic harm. The County must implement and normalize these core competencies throughout its entire crisis system of care.

4. Make significant investments in peer-informed and peer-delivered services.

I recommend that, over the next twelve to eighteen months, the County make significant investments in peer-informed and peer-delivered Crisis Intervention and Crisis Treatment Services. My primary recommendation for achieving this goal is to hire and incorporate Peer Specialists with lived experience in behavioral health crises into the County's crisis system. Peer Specialists can assist the County in meeting the minimum standards described herein, including by staffing Crisis Intervention teams and helping to implement recovery-oriented, person-centered, voluntary, and trauma-informed care.⁷⁵ Peer Specialists must be fully integrated into crisis services. Their responsibilities must go beyond greeting or supporting individuals who are receiving coercive care as usual.

Based on my review and interviews with the County, there are currently no Peer Specialists involved in PET crisis services. Although the County indicated that it has hired some peers to work in other areas, that is not sufficient to illuminate and challenge harmful assumptions underlying the County's crisis system or remedy the County's coercive practices.

Peer-led organizations may be able to assist the County in recruiting, training, and supporting Peer Specialists embedded in the workplace. To be effective, these organizations must be led and largely staffed by individuals with lived experience who have a vision of system transformation, and who are well-trained in the core competencies discussed above and recovery models of care.⁷⁶ The County should consider providing funding and grant opportunities and creating seats at decision-making tables for peer-led organizations with experience in crisis care.

5. Drastically reduce law enforcement involvement in crisis care.

I recommend that the County take immediate steps to reduce law enforcement involvement in crisis services. The County should revise its policies and practices providing that crisis teams will not respond without law enforcement. The County should limit law enforcement's role to (1) providing back-up support in potentially dangerous situations *after* Call Center staff or Crisis Intervention teams have assessed the need, or (2) as a referral source delivering warm hand-offs to crisis staff in the limited situations in which law enforcement is the first to become aware of a crisis. Because law enforcement is currently the first response to 911 calls, the County will need to work with law enforcement and emergency service agencies to ensure that 911 dispatch is able to coordinate directly with the County for Crisis Intervention deployment.

In addition, and to the degree that it is not already happening, all officers should receive training on mental illness, substance use and abuse, psychiatric medications, and strategies for identifying

⁷⁵ *Id.* at 3.

⁷⁶ DHCS Assessment at 88.

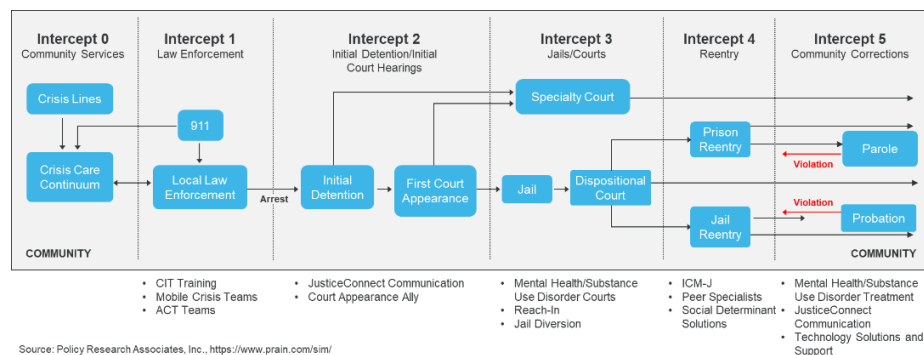
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and responding to a crisis. In addition, law enforcement agencies should continue their efforts to train and designate a specialized and qualified subset of officers in Crisis Intervention Training (CIT).⁷⁷

6. Identify early-diversion and -intercept opportunities to reduce the number of people receiving mental health treatment in jails.

To address the disproportionately high number of people with mental health disabilities in County jail, I recommend that the County develop programs to divert people from the criminal system at the earliest point of contact, either before or immediately after arrest.

Intercept Zero. The Sequential Intercept Model, pictured below, has been used to decrease representation of individuals with mental health and substance use conditions in the criminal system. As with the crisis system, the goal is to intervene as early and as far upstream as possible. An effective crisis system fits neatly into Intercept Zero: in lieu of 911, a person calls a Crisis Call Center and gets a trained mental health system response that is designed to resolve crises in the community without any law enforcement involvement. The recommendations in this report, including Crisis Intervention and Treatment services, will help Tulare County develop its Intercept Zero services.



Intercepts One and Two. Based on my review and interviews with the Sheriff’s department, jail staff, the Public Defender’s office, and residents involved in the criminal system, it is my opinion that the County needs additional strategic investments at Intercept One and Two. While many law enforcement officers in the County are trained in CIT (an Intercept One strategy), they have few options for diversion from emergency departments or arrest. Consequently, the benefit of the County’s investment in CIT is not fully realized. Intercept One and Two programs can help

⁷⁷ The best practice is to carefully select officers well-suited to CIT work, who do not have disciplinary issues. The CIT Center at the University of Memphis, which offers resources for CIT programs nationwide, makes the following recommendations: “The CIT officer’s role involves increased responsibility and accountability, so it’s important to choose officers with a strong character and a temperament suited to responding to people in crisis. . . . In order to find the officers best suited for CIT, many programs rely on officers to volunteer for the program.” CIT Center, University of Memphis (last visited Feb. 24, 2022), www.cit.memphis.edu/engagement.php?id=4&page=5.

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the County realize its investment by providing mental-health-system engagement *in lieu of jail* and *instead of* an alternate disposition through a specialty court.

At Intercept One, law enforcement has become involved. The intercept opportunities are to use CIT trained officers, which the county has done, but to then develop opportunities for the crisis to be addressed in the community. Intercept One strategies are used “in lieu of arrest,” for example by transporting a person to a voluntary sobering center instead of arresting and transporting to jail on a “cite and release.” At Intercept Two, a person has been arrested, and here there are additional diversion opportunities. Although Intercept Two programs may include diversion at the initial court hearing, I recommend that Tulare County invest in Intercept Two programs designed to divert people at the point of an initial detention, before they are booked into jail and in lieu of proceeding to a court hearing.

I recommend that the County develop and implement at least one Intercept One program and at least one Intercept Two program designed to divert people to community-based mental health services. The County may rely on an independent pre-trial agency and/or social workers to identify and recommend people who can be diverted in lieu of being charged and booked into jail. Other Tulare County solutions include services for people with substance use disorders, such as Sobering Centers that provide safe short-term places for patients waiting for substance use intoxication to subside while being supported and monitored and then connected to appropriate longer-term services.⁷⁸

7. Make strategic investments in essential components of a crisis system of care.

I recommend that the County strategically invest in the missing essential components of a crisis system, in accordance with the minimum standards described in this report. These investments should be data-driven and informed by the assessments recommended above. I also recommend inviting non-governmental outpatient treatment providers and peer-led organizations to participate in new initiatives and view them as essential players in the crisis system.

My recommendations for these strategic investments are as follows:

- **Within six months, modify the County’s Access Line operations in order to meet the minimum standards for a 24/7 Crisis Call Center.** The County should maximize the telephonic Crisis Intervention and de-escalation support available through NSPL-trained staff as a least-restrictive crisis intervention.
- **Within twelve months, implement at least two new Crisis Intervention service teams led by mental health and Peer Specialist staff.** Crisis Intervention staff should be trained to respond exclusively in the community with limited law enforcement involvement and provide brief, resolution-focused, voluntary treatment. The importance

⁷⁸ California Health Care Foundation, *Sobering Centers Explained: An Environmental Scan in California* at 4 (September 2021), www.chcf.org/wp-content/uploads/2021/07/SoberingCentersExplainedEnvironmentalScanCA.pdf.

of this investment cannot be overstated, and is described more fully in Recommendation Two, above.

- **Within eighteen months, develop voluntary, peer-rich, Crisis Treatment Services** that provide community-based, walk-in crisis support with capacity for very short crisis stabilization that meets the minimum standards above, offered in home-like, non-hospital environments. I recommend that Tulare County use the recent DHCS assessment as a starting point for considering how to build out this capacity. DHCS’s recommendation that Tulare County add 22 crisis stabilization beds is helpful guidance, but I encourage the County to examine closely how best to meet the community’s needs *beyond simply adding treatment beds*. As discussed above, peer-led organizations may assist in developing alternatives to conventional treatment facilities, for example by supporting in-community peer-stabilization, peer respites, crisis apartments, and peer-led outreach and engagement. All services should incorporate Peer Specialists to the greatest extent possible.
- **Within eighteen months, develop a peer-rich, community-based Sobering Center** that involves supportive engagement with staff that offer information on community resources and treatment options and facilitate access to care as an individual becomes ready to take that step, including MAT.⁷⁹ This could substantially reduce the number of individuals currently arrested through the “cite and release” practices.
- **Within eighteen months, develop and implement at least one Intercept One program and at least one Intercept Two program to divert people to behavioral health services.** This investment should be made in partnership with the Sheriff, Public Defender, and District Attorney.

Without these intentionally designed crisis services, the County will continue its heavy reliance on coercive treatment, law enforcement, hospitals, and jails—all of which are minimally effective yet painful, stigmatizing, and traumatizing for the person being treated. It would be an unfortunate and critical error if the County were to seek a quick solution—for example, investing in a new crisis drop-off center as an alternative to hospitals, and believing that this will solve the problems described herein and meet minimum standards. It will not, and the County will lose the attention of key partners stakeholders who may incorrectly believe that the work is complete. Instead, the County should purposely arrange the services above to operate in a coordinated and systematized fashion. To aid in this, I recommend developing an organizing framework that includes a visual map of current services and identifies opportunities to expand and add the components above.

⁷⁹ DHCS Assessment at 80, 91.

8. *Strengthen data collection systems and use them to drive improvements to the crisis system on an ongoing basis.*

I recommend that the County take immediate steps to strengthen its data collection systems and analyze crisis data, and that it continue to do so on an ongoing basis in order to drive improvements to the system. I recommend that the County do this by: analyzing and responding to data immediately and on an ongoing basis; improving data systems; sharing data across agencies; and identifying opportunities for strategic partnerships to improve the system of care.

Ongoing Data Analysis and Response. I recommend that the County implement a policy of ongoing data analysis in order to understand and respond to the clinical needs of people being served. The County's analysis should identify and measure: the nature of crises experienced by residents (which may evolve over time); gaps in service and care-quality issues that increase the risk of coercive care; health disparities; the percentage of crisis responses resolved in the community versus institutions; the percentage of involuntary commitment referrals converted to voluntary; the percentage of referrals diverted from the criminal system; and consumer service satisfaction.

Because each involuntary hold offers an opportunity to understand the factors resulting in its use, the County should collect data relating to all behavioral health crisis calls and all 5150 and 5585 evaluations in the County and analyze any use of coerced care that is not specifically clinically necessary for the individual in question. In addition, for each behavioral health crisis call, the County should analyze:

- Who initiated the call and why;
- Whether the call came in through the Access Line, 911, or law enforcement and why;
- Whether law enforcement was involved;
- Whether Crisis Intervention could have been provided in the community without law enforcement involvement; and
- Whether there are trends in over- and under-utilization of services in general and in 5150, arrest, and emergency department usage data in particular.

The County should also track data relating to consumers' cultural orientation and whether any groups are over- or under-utilizing services, and recruit and train staff accordingly. When problematic patterns and coercive practices are indicated, the County should investigate and mitigate the patterns as soon as possible, including through immediate outreach to relevant partners. To achieve this, the County must quantify data in a way that enables analysis across agencies and systems.

Key indicators of successful data analysis and response include:

- Reduction in law enforcement "touches" during any aspect of a crisis episode;
- Decreased use of emergency departments;
- Decreased use of 5150s;
- Increased crisis resolution in the community;

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- Increased telephonic resolution; and
- Increased adherence to any agreed upon “next service” demonstrating a good fit and consensus decision-making.

Improving Data Systems. To facilitate ongoing data analysis and response, the County should take immediate steps to improve its data systems. The County’s existing systems are largely siloed by service sector, and not sufficiently vetted at a cross-systems level to assure data is accurately captured, labeled, and analyzed with the goal of minimizing coercive care and maximizing efficiency and effectiveness. The County can address these challenges by creating an electronic data dashboard and a system for tracking crisis service demand, trends, and patterns in real time. Creating a real-time tracking system is critical, as lagging data (for example, data that is 30 days old) is minimally relevant to a crisis system that needs to respond to today’s demand and to anticipate tomorrow’s needs. In a number of communities, a robust Call Center has become a centralizing and coordinating hub of crisis system activities, and has helped to gather, analyze, and make available in real time the performance data of the crisis system.⁸⁰

In developing its data systems, the County should also partner with the various agencies involved in crisis care, including the Access Line, 911, HHSA and Crisis Intervention staff, hospitals, and law enforcement. After establishing responsibilities and agreeing upon key data and definitions, the County may rely on these agencies to populate the system with data from each service episode. Such data may be collected by imbedding questions into scripts and provider protocols.

Data Sharing Across Agencies. Because data collection and analysis are key to implementing a comprehensive and integrated crisis system of care, agencies must also endeavor to share data in real time whenever possible. Data-sharing among agencies engaging with people in crisis can improve outcomes, for example by diverting people to services that mitigate or even prevent a mental health crisis before the risk of hospitalization or arrest is present.

Data-sharing can be implemented in various ways, including through sharing health records where permitted and by case-conferencing with relevant stakeholders in order to closely coordinate resources for individuals needing greater support. Establishing procedures to formalize inter-agency data-sharing and reviewing data regularly and collaboratively ensures that agency responses reflect community needs and make efficient use of limited resources.

Strategic Partnerships to Improve the System of Care. Ongoing data analysis can also lead to strategic partnerships and investments to improve the system of care. For example, if a common finding is that people are homeless or experiencing housing instability, there may be new ways of partnering with housing providers or addressing mismatches between existing housing stock and the needs of the persons in crisis. If an observation is that suicidality has increased, underlying systemic factors may need to be addressed, such as food/clothing/shelter insecurity or

⁸⁰ The County may also benefit from learning about other emergency response systems, including police, fire, EMS and disaster response models, which must consider timely response, supply and demand issues, and response to surges.

a lack of services related to trauma, grief, and social isolation, among many others.⁸¹ Data relating to referrals from schools, nursing homes, board and care facilities, and other congregate care settings can facilitate partnerships with those entities that support in-vivo stabilization and builds the crisis competencies of those partners. Data relating to individuals served by multiple systems, for example children who are involved with child protective services or juvenile justice systems, will help to identify specialized practices to support those youth and their families.

CONCLUSION

My opinion is that Tulare County fails to meet minimum standards for behavioral health crisis services and improperly relies almost exclusively on coercive crisis intervention strategies, institutionalization, and detention to treat people experiencing behavioral health crises, even when community-based services would be appropriate. These policies and practices create a significant risk of trauma and iatrogenic harm for the County residents being served, including a significant risk that people could be institutionalized or jailed due to the harmful effects of the County's current treatment modalities. The County also lacks the essential components and qualities of a crisis response system, and as a result, fails to provide crisis services voluntarily, at the right time, in the right setting, and in the appropriate amount, duration, and scope. However, as the central government entity responsible for crisis system components, the County is well-positioned to bring its services in line with minimum standards by implementing Recommendations One to Eight, above. The County's efforts will benefit from what I perceived to be a widely held and genuine desire to provide clinically appropriate services and pre-existing investment in relationship-building and cross-agency collaboration, which is critical to improving crisis services across systems.

⁸¹ These factors may also include: aging-related stressors; dual conditions; multi-system involvement; school stressors; domestic violence; and health disparities leading to access, quality, and safety concerns.

SUMMARY OF EXPERIENCE

Kappy Madenwald, MSW, LISW-S

CONSULTATION AND TECHNICAL ASSISTANCE

New Hampshire

September, 2021 and ongoing

This project includes the delivery of consultation and team training as New Hampshire prepares to roll out mobile crisis services in January, 2022

Louisiana

August, 2018 and ongoing

Engaged by the Technical Assistance Collaborative for the Court Monitor in the Agreement between the State of Louisiana and the Department of Justice to provide consultation and technical assistance to Louisiana Office of Behavioral Health. Primary goals of the agreement are diverting individuals with serious mental illness from inappropriate placement in nursing homes and assisting individuals who are able and interested in transitioning out of nursing homes into community-based settings. My work focuses on partnering with the state as they develop a statewide crisis system of care for adults. These new services will go live in 2022.

Philadelphia Department of Behavioral Health and Intellectual disAbility Services

June, 2016 and ongoing

Providing ongoing technical assistance and consultation to the department in the assessment, redesign, procurement, and rollout of its crisis system of care for children and adolescents in the city/county of Philadelphia. Additional scope of work includes provision of training, coaching and consultation to recent awardees of five new levels of crisis service response as well as a new centralized crisis line/dispatch team. Training and coaching about crisis system of care development, infusion of parent peer support positions into work teams, and delivery of non-traditional, strength-based, youth/family centered and resolution-focused interventions designed to improve health, reduce use of inpatient hospitalization and promote community tenure.

In 2021, this project shifted to transformation of the adult crisis system of care included a re-envisioned service model, and expansion of mobile crisis response capacity.

Idaho

July 2020-May, 2021

Design and delivery of an intensive training and coaching series for newly formed mobile crisis team members; topical consultation to state and regional leadership teams and other crisis system-related projects

April-October 2019

This project involves a statewide evaluation of existing crisis services and recommendations for a new crisis system of care. This engagement also involves regional coaching and state-level consultation in the redesign of the crisis system of care.

Massachusetts

May 2020-January, 2021

Delivery of a coaching and training series on supporting children in crisis and their families for In-Home Therapy (IHT) teams

June 2019-December 2020

This is a return engagement to the Commonwealth to provide a series of training, coaching and consultation services to 21 teams that provide Mobile Crisis Intervention to children and youth in Massachusetts.

Washington

November, 2016 and ongoing

Working with Beacon Health Options through its contract with the Washington State Health Care Authority (HCA), Molina Healthcare of Washington and Community Health Plan of Washington as it invests in comprehensive crisis system of care for children and adults in specific regions of Washington where it holds or seeks to hold contracts. Goals include reducing use of coercive interventions including the use of involuntary treatment, expanding community-based and mobile crisis intervention, infusing peers into crisis service delivery, decreasing length of crisis episode and particularly lengthy ED holds. Scope of work includes an evaluation of the crisis system of care, training, consultation, support of crisis system of care workgroups, and RFP support.

Milwaukee, WI

January-September, 2018

In collaboration with HSRI and TAC, serve as part of a team of consultants providing a comprehensive review of Milwaukee County's crisis system of care that will lead to recommendations for redesign.

Protection and Advocacy for People with Disabilities, South Carolina

2016, 2018

Providing subject matter expertise to the Protection and Advocacy team on Olmstead-related complaints.

Massachusetts Children's Behavioral Health

July, 2015—June, 2016 and Feb—June, 2018 Intensive training and coaching series to seventeen "***Caring Together Continuum Teams***" in Massachusetts that are delivering innovated, community-based services to youth and their families in lieu of long-term residential treatment. Using a family-centered care approach, the focus of the training/coaching series is: *Building Competency in Effective Crisis Planning, Prevention, Support and Early Intervention*

Intensive training and coaching series for ***staff of school-based health centers*** in addressing the needs of students experiencing a mental health crisis and engaging/supporting the families of those students. Focus of the series includes: Family-centered care, resolution-focused crisis intervention, safety planning, and effective collaboration with the school and community services that support youth in crisis

Massachusetts Department of Mental Health

Southeast Region Emergency Services Programs

January 2014—June, 2015. August, 2016—February, 2017

This extensive project has involved assessment, consultation, training, systems development and other technical assistance focused on the department's operation of four mental health emergency services programs (ESPs) in the Southeast region of Massachusetts including Cape Cod and the surrounding islands. The ESPs each operate site-based crisis services, mobile crisis services and multi-bed brief crisis stabilization units. This consultation includes focus on each of the ESP components, Crisis Systems of Care at a regional and local level, operational, programmatic efficiencies and competencies, interface between ESPs and regional hospitals, law enforcement agencies, and other service providers. Of particular emphasis is a goal of reducing the number of people being evaluated/having extended length of stay in emergency departments, reducing use of involuntary processes, and increasing team proficiency in delivering person-centered and resolution-oriented crisis intervention services.

California

2015, 2016, 2017

- *Ventura County DMH*
- *Ventura County CFS*
- *Santa Barbara County*
- *Casa Pacifica*

- *Seneca Family of Agencies*
- *San Francisco Department of Public Health*

Provision of a range of one-time or ongoing training and consultation services to select counties/agencies in California on developing Crisis Systems of Care for children and adults and enhancing competency in delivering family-centered and resolution-focused services within a variety of human services settings

CMHACY Annual Conference

Pacific Grove, CA

May 11-12, 2016

Plenary: *Achieving the Promise of Family-Centeredness in Care Delivery*

Breakout session: *Notes from a Recovering Expert: The Bumpy Road on the Way to Family-Centered Care*

Centre for Addiction and Mental Health (CAMH)

Toronto, Ontario

March—April, 2016

The Peel Services Collaborative consists of representatives from human services providers among multiple sectors along with advocacy groups and religious leaders. With support from CAMH, and building on the work of the children's collaborative (see January, 2014) CAMH is implementing an adult version of a series of crisis planning tools and accompanying provider's guide that were originally developed by Madenwald Consulting with and for the state of Massachusetts. This project includes technical assistance in the local modification of the tools, implementation strategy and the development of training curriculum and tools. Provided on-site training of multi-system teams who work with adults, including transition-aged adults, focused on family-centered planning and crisis support designed to reduce over-reliance on traditional emergency services and reactive/directive/coercive responses to crisis situations.

Massachusetts Executive Office of Health and Human Services

January 2015 and ongoing

As a consultant with the Technical Assistance Collaborative, Inc. and at the request of the parties to the *Rosie D vs. Patrick* class action suit, this project is focused on maximizing the delivery of community-based versus emergency department-based crisis services for children. Tasks include a review of the services being delivered by the 21 statewide emergency services programs, review of data, written report and consultation to the parties; development and delivery of regional training to youth MCI teams, and delivery of two rounds of MCI agency-specific coaching and consultation.

New York University Child Study Center

February 2013—Ongoing

Serve as a consultant and "interventionist" to the New York University Child Study Center research team on a 5-year NIMH-funded research project called Family to Family. (R01 MH085969. PI: Hoagwood) In partnership with an expert in organizational culture and climate from The University of Tennessee, this project involved the provision of direct training, coaching and consultation services to waiver teams and their parent agencies in New York State randomly selected to receive the "intervention" with a focus on enhancing broad team skill in delivering family-centered care. The intervention included full-day large group training followed by monthly team-specific, on-site consultation, and consultation to senior and executive leadership as indicated on the delivery of family-centered care. The focus of the project is now on outcomes.

January 2012—December 2016

Served as consultant to the New York University Child Study Center research team. NYU has teamed with **Nationwide Children's Hospital** in Columbus, Ohio and **Akron Children's Hospital** in Akron, Ohio to develop the "Parent Partner Initiative." Responsible for curriculum development, training and coaching of Parent Partners and clinicians who work with children and families in crisis. Contributed to research design, identification of outcomes, review of best and promising practices and building a body of resources for use by the program. The Parent Partner Initiative at Nationwide Children's and Akron Children's Hospitals adds Parent Partners to the interdisciplinary teams that work with children in crisis and their families. The project re-orientes the entire team

to a family-centered program model. Program goals include use of Shared Decision Making, increased parent activation and social support, increased adherence to treatment and a reduction in repeat use of the emergency department and inpatient psychiatric beds.

Center of Vocational Alternatives (COVA), Columbus, Ohio
February, 2013-December, 2015

Provided technical assistance and consultation as COVA envisioned and successfully sought funding for a peer operated program called RecoveryWorks that provides online and in person peer support, guidance and resources for those challenged with mental wellness and addictive behaviors. Provided training and ongoing consultation to the team of adult Peer Specialists and program leadership as they engaged and supported members.

Green Chimneys, Brewster, New York
August—December, 2015

Green Chimneys provides residential, day treatment and community based services to children and adolescents. This project involved consultation, training and coaching in support of a transformation project aimed at improving the care experience of families, improving health outcomes for kids and team and in reorienting to a family-centered care model. An all-staff training series was followed by a series of team-specific coaching sessions aimed at transfer of training competencies to practice.

Centre for Addiction and Mental Health (CAMH)
Toronto, Ontario

January—December, 2014

The Peel Services Collaborative consists of representatives from human services providers among multiple sectors along with advocacy groups and religious leaders. With support from CAMH, the collaborative is implementing a modified version of a series of crisis planning tools and accompanying provider's guide that were originally developed by Madenwald Consulting with and for the state of Massachusetts. This project includes technical assistance in the local modification of the tools, implementation strategy and the development of training curriculum and tools. On-site training of early adopters of the tool was delivered in February with a focus on the "why" of person/family-centered safety planning and crisis support with curriculum that increases awareness of the risk of over-reliance on traditional emergency services and reactive/directive/coercive responses to crisis situations. Ongoing consultation to the Peel Collaborative includes delivery of additional training, coaching and technical assistance as local tools, training modules and processes are developed.

Cenpatco Arizona
May-October, 2014

Consultant to Cenpatco as part of a panel of content experts and writers assembled by HTMS to assist in this MCO's winning response to a Medicaid RFP with extensive expectations around crisis system development and performance. Cenpatco was awarded the contract in December, 2014.

Community Healthcore: Longview, Texas
August 2013—December 2014

Consultant to Community Healthcore in the development of a *Crisis System of Care* that creates local, less-restrictive, alternatives for persons experiencing a mental health or substance use crisis. Community Healthcore—the primary provider of community-based behavioral health services in East Texas—is in the process of developing three Regional Crisis Response Centers in partnership with regional hospitals through funding under the Texas 1115C Medicaid Waiver and the Texas Department of State Health Services. The end goal for this project is not only to expand local, acute crisis resolution services on the front end of the Waiver process, but for Healthcore to use this unprecedented opportunity to plan and develop a *Crisis System of Care* throughout the nine county service area that promotes crisis prevention and early intervention and decreases need for/reliance on law enforcement, emergency departments and court-ordered treatment. The scope of this consultation involves evaluating the existing crisis service array; studying current practices and competencies; and making recommendations for development of the system with a specific emphasis on embedding peer-delivered services in multiple points of the crisis system.

New Mexico Behavioral Health Collaborative: Crisis Systems of Care

March 2012—September 2014

Consultant to the Behavioral Health Collaborative of New Mexico, in response to the recommendations of New Mexico House Joint Memorial 17 to improve behavioral health crisis services throughout the state by building effective Crisis Systems of Care. Facilitated a 2-day symposium. Provided intensive on-the-ground technical assistance, training and consultation to Guadalupe, Taos and San Juan Counties as they developed/implemented CSOC components in their respective communities. Consultant to the HJM 17 Task Force. In 2014 worked with Taos County to develop a manual that describes the development of the Taos County Crisis Systems of Care Alliance and continue to provide technical assistance and coaching to the alliance as it has secured a grant to reduce suicide in Taos County.

Massachusetts Behavioral Health Partnership (MBHP)

October 2008—December 2013

Expert consultant to MBHP, under the direction of MassHealth, Office of Behavioral Health in the development and implementation of the new Mobile Crisis Intervention (MCI) service—one of seven expansion services for children and families developed as a result of the *Rosie D vs. Patrick* class action suit. Previous and ongoing components of this consultation include but are not limited to the development of service specifications, assisting in the writing of the Request for Response (RFR) for the procurement of the Emergency Services Program (ESP) that is inclusive of the new mobile crisis service for children and families, development of RFR review and scoring guidelines, provision of extensive statewide technical assistance to ESP providers in readying for, rolling out the MCI service and evaluation of fidelity to the service model. Technical assistance includes on-site coaching of crisis teams, clinicians, Family Partners and managers, consultation to ESP Executive Directors and senior staff, developing and facilitating a number and variety of regional and statewide training seminars, and consultation to MBHP senior and management staff designed to build competency across the service network. With input from a broad array of stakeholders, developed a comprehensive set of “Safety Planning Tools” for individuals and families; a companion guidebook for providers and a full-day, hands-on training on implementation of the tools. Brought together clinical directors and program managers of multiple levels-of-care for a two-part training series on building crisis systems of care across levels-of-care. Trained managers of In-Home Therapy Programs in building the capacity of their teams to deliver strengths-based interventions. Wrote an Operations Manual for teams that deliver the Mobile Crisis Intervention (MCI) service. Throughout this extensive project, have served as a consultant to the Managed Care Provider (MBHP), State Office of Behavioral Health and the Court Monitor.

Department of Justice

Washington, DC

July 2011—Ongoing

Provide periodic consultation to the Civil Rights Division of the Department of Justice in its assessment of whether a state is satisfying its responsibilities under the American with Disabilities Act, as interpreted in the *Olmstead* decision; and around consideration of remedies which often include some expansion of community-based crisis services and supports

Iowa Department of Health and Human Services

July-December, 2011

Served as one of a five-member team of experts from the Technical Assistance Collaborative (TAC Inc.) in facilitating workgroups focused on the redesign of Iowa’s mental health and developmental disability services system as authorized by SF525. Facilitated the Children’s MH&DD Workgroup; comprised of statewide stakeholders that included service providers, parents and advocates, and state and county administrators. Guided review of local and national best and promising practices, review of current practices and the development of a series of recommendations for the children’s MH&DD system redesign and assisted in development cost estimates for the new system structure and service array that is now being considered by the Legislature.

York/Adams Health Choices, Pennsylvania

December 2008—June 2011

As a subcontractor to and in partnership with the Executive Director of Hartman and Associates, this project involved an extensive review of the York/Adams crisis system, an evaluation of each service component inclusive of broad satisfaction measures, and development of strategic recommendations to improve efficiencies and strengthen the community safety net. Current focus is in developing the competency of the clinical teams and the broader crisis system of care.

The Annapolis Coalition on the Behavioral Health Workforce

September 2007-April 2010

Consultant and Director of Operations for the Annapolis Coalition; a not-for-profit organization dedicated to improving the recruitment, retention, training, and performance of the prevention and treatment workforce in the mental health and addictions sectors of the behavioral health field.

Northern Iowa Behavioral Health Crisis Services

June-August, 2010

As a subcontractor to TAC, Inc., provided consultation to a multi-county (largely rural) collaborative stakeholder group in an assessment of current crisis system resources, strengths, and gaps. Assisted in the development of a response to a competitive RFP.

New Mexico Department of Human Services, Behavioral Health Division

October-December 2009

Provided training and consultation to New Mexico DHS and provider agency staff during the Division's Annual Collaborative Conference. Provided both a national perspective and state-specific considerations on developing community-based behavioral health crisis systems that are strengths-based, consistent with recovery/resiliency principles and that promote care that is close to home and in the community. Focused on strategies such as shifting service paths away from those that are more likely to result in restrictive care, assuring "upstream" interventions, maximizing the use of natural supports, developing systemic partnerships and increasing competency in resolution-focused crisis interventions, communities can effectively increase community tenure for children and adults in a manner that is consistent with public safety.

Crossroads LME, North Carolina

January-June 2009

As a subcontractor to and with the Executive Director of TAC, Inc. this project involves assisting Crossroads in the completion of a three-year strategic plan. This involves the engagement of numerous stakeholder groups in determining system priorities and service gaps.

Rosie D vs. Patrick, Massachusetts

June-October 2008

As a senior consultant and sub-contractor to the TAC, Inc., joined a team of national consultants led by John O'Brien in assisting the Court Monitor in the *Rosie D vs. Patrick* class action suit in developing and implementing strategies for expanding behavioral health services for children under 21 years of age and their families. This included helping the state and its managed care vendors to develop service definitions and medical necessity criteria for seven new services with specific leadership in developing Youth Mobile Crisis Intervention and Crisis Stabilization Services.

Maryland Health Care Commission

March-May 2008

As a subcontractor to John O'Brien, co-wrote a white paper on effective crisis response and diversion strategies. The paper included a summary of relevant research and a description of existing prevention and diversion services in Maryland.

Maryland Department of Mental Hygiene

February-July 2008

As a subcontractor to TAC, Inc., was part of a team of consultants that assessed current residential services programs for persons with mental health, substance use or developmental conditions. Outcomes included an

increased understanding and documentation of the existing constellation of residential resources for priority consumers in Maryland, identification of strategies to increase the degree to which the existing resources foster recovery and reflect best practices, identification of potential strategies to expand the supply of permanent supportive housing for people with mental illness or co-occurring mental illness and substance abuse in Maryland; and integration of strategies related to residential services and supportive housing with other system transformation planning activities now underway in Maryland.

**North Carolina Division of MHDDSAS
February-June 2008**

As a subcontractor to TAC, Inc., was part of a team of consultants that assisted the Division in a review of persons living in adult care facilities and group homes across the state. Outcomes included the completion of a needs assessment and gaps analysis for persons living in or at risk of living in adult care or group home facilities, and assisting in the development of service models to support persons in permanent supportive housing as an alternative to congregate care.

**North Carolina Division of MHDDSAS
December 2006-June 2008**

As a subcontractor to the TAC, Inc. served as a senior consultant on a team that assisted North Carolina in the development of state-wide community based comprehensive crisis programming that provides recovery-oriented services and reduce admissions to state hospitals. Developed and provided training in the use of the comprehensive template by each region in creating both local and regional crisis plans. Individualized technical assistance to Local Management Entities (LMEs) continued through June 2008.

**Jackson County Mental Health Services, Medford, Oregon
January-December 2007**

As subcontractor to TAC Inc. served as a senior consultant on a team that assisted Jackson County Mental Health and its community partners in evaluating the local crisis services continuum, advising on the feasibility of building a local crisis stabilization unit to offer diversion from psychiatric hospitalization, identifying opportunities for efficiency and improving service quality and care coordination.

**North Carolina Division of MHDDSAS
March 2005-May 2006**

Developed and implemented a plan to introduce Mobile Crisis Management services, a newly-defined service, throughout the State, through a series of on-site trainings, consultation and technical assistance initiatives coordinated through the Behavioral Healthcare Resource Program at University of North Carolina at Chapel Hill.

**CASA Pacifica, Santa Barbara, CA
November 2005**

Provided technical assistance and training to the executive, senior and clinical staff of CASA Pacifica as they implemented a newly awarded mobile crisis services program for children and families.

**Guilford Center, North Carolina
November 2004-January 2005**

As a subcontractor to TAC Inc. was part of a team that reviewed the crisis services program at the Guilford Center. Reviewed the staffing model, service utilization patterns and clinical protocols and made programmatic recommendations as part of this technical assistance review.

CLINICAL AND ADMINISTRATIVE SERVICES

**Alcohol Drug and Mental Health (ADAMH) Board Of Franklin County, Columbus, OH
January 2005-August 2007**

Director, Clinical Services

First person to fill this position that was created to expand clinical leadership at the ADAMH Board. Directly supervised Clinical Manager and Consumer Services Manager positions. Responsible for a broad range of clinical oversight and strategic planning initiatives aimed at improving the clinical quality, efficiency and cost effectiveness of Board service investments for all populations served by the ADAMH Board's contract agencies. The ADAMH Board contracts with 40 community providers of mental health, alcohol and other drug treatment and prevention services who combined serve 35,000 consumers each year.

Responsible for the evaluation of contract provider performance and contract compliance, the review of Agency Service Plans and commitments, collaboration with Board fiscal staff in assuring continuity between agency budget and service commitments, making recommendations for programmatic investments and evaluating the outcome of those investments. Responsible for overseeing the purchase of nearly \$12,000,000 of state hospital services, meeting or exceeding annual utilization targets. Responsible for collaborating in the writing and submission of grants to local, state and federal entities.

Play an active role in ADAMH Board Department of Public Affairs ongoing campaigns to promote good mental health, recovery and reduce stigma. As Clinical Director, participate in dozens of pitched and reactive television, radio and print interviews each year. This includes live and call-in formats.

Represent the Board in statewide initiatives and committees through the Ohio Association of County Behavioral Health Authorities (OACBHA) with primary responsibilities in the Clinical Leadership and State Hospital Services workgroups working with representatives from ODMH and ODADAS as well as representatives from boards throughout Ohio.

Key accomplishments include:

- A reduction in the use of state hospital bed days,
- A reduction in Franklin County Central Pharmacy expenditures
- The creation of a liaison program between private hospitals and community mental health agencies
- The implementation of a crisis continuum model as part of a work plan to decrease clinical risk and improve coordination of care between treatment agencies, 24/7 crisis agency and the state hospital
- The expansion of services targeting persons involved in both the criminal justice and behavioral healthcare system
- The expanded and effective use of evidence-based practices
- Expansion of services shown to be keys to recovery and an array of initiatives aimed at prioritizing rapid access to services for persons with urgent and emergent treatment needs.
- Developing, issuing and evaluation RFP's for targeted programmatic expansion
- Led a 12-month system quality improvement analysis followed by an array of initiatives aimed at addressing factors that lead to rapid hospital readmission.

Netcare Corporation, Columbus, OH November 1996-January 2005

Director, Clinical Services

Responsible for clinical oversight, staff recruitment, retention and competency as well as strategic planning and program development at this large behavioral healthcare provider. Netcare Corporation is the primary provider of Mental Health and AOD crisis and assessment services in Franklin County, serving both children and adults and providing more than 30,000 episodes of care each year. Had direct responsibility for the Clinical Management Team comprised of 6 Program Managers and 13 Team Leaders who, combined, supervise more than 120 line staff members.

Responsible for clinical and administrative direction of the following programs:

- Two 24/7 crisis and assessment services sites
- Crisis Stabilization Unit (7 day hospital diversion unit for adults)

- Miles House (short-term crisis residential adult group home)
- Emergency Response Services (24-hour telephone triage)
- Probate Prescreen
- CISM Services
- Community Crisis Response Team (CCR)
- Reach Out Program
- Older Adult Mobile Assessment
- Forensic Services

Additionally, have previously directed the following programs:

- Youth Services mobile crisis and assessment team
- Youth and Family Team based at Franklin County Children Services
- Youth and Adult Court Services team

Other responsibilities include: Active involvement in agency Quality Assurance and Risk Management programs, corporate orientation, development and implementation of Corporate Policies and Procedures, recruitment, retention and evaluation of clinical staff, program development, and intersystem initiatives among other Senior Staff level responsibilities. Provide clinical training on broad range of topics including: Clinical documentation, HIPAA, risk management, Crisis intervention services, Mental Status Exam, Crisis Intervention with Children and Adolescents, Differential Diagnosis in Children, and Grief and Trauma in Children.

Key Accomplishments Include:

- Envisioned and led in the design of a web-based electronic clinical record that now supports all of Netcare's clinical activity in a highly, interactive, usable, efficient and compliant with HIPAA security standards. The tool works in multiple sites throughout the county and using wireless cards mobile staff access the tool while in the community. The tool created a seamless interface between the delivery of services and processing of claims—there is no duplication or transcription required. Redundancies in data entry were largely eliminated—information previously entered is available for review or update during subsequent episodes. Current productivity reports can be accessed by staff or managers at any time. Active census information is available through any work station throughout the agency. Worked with the agency IT director and contract programmers throughout the 12-month process. Staff from throughout the agency participated in the development of clinical tool specifications assuring that virtually all staff gained efficiency with the final project.
- Developed a performance evaluation and professional development program for support staff, clinical staff and managers.
- Produced a comprehensive "Clinical Documentation Strategies" handbook for use by clinical and paraprofessional staff.
- Developed and led a 12 month restraint-reduction initiative and reduced both the number of restraints and the average length of restraints by more than 30%.
- Led and participated in numerous strategic initiatives designed to enhance key business drivers such as clinical performance, service efficiency, productivity, revenue enhancement and workplace satisfaction.

Manager, Youth Services

November 1996- February 2000

From November 1996 until promotion to Director of Clinical Services in February 2000, was manager of the Child and Adolescent Mobile Crisis and Assessment Team.

Supervised a team of 14 professional counselors and social workers in providing mobile and site-based mental health, alcohol and other drug services to children under the age of 18. Additionally, supervised Netcare staff located in the Franklin County Juvenile Detention Facility. Participated in collaborative efforts with the ADAMH Board of

Franklin County, Franklin County Children's Services, Community Mental Health

Centers and Community Schools, ACT and community hospitals in planning for services and coordinating care for young people and their families.

The Ohio State University Medical Center, Columbus, OH
November 1989—November 1996

Senior Social Worker

Psychiatric Social Worker on child and adolescent inpatient unit. Completed psychosocial assessment of each family with specific focus on safety issues, parenting skills and supports/resources. Provided intensive family therapy, parent guidance and education. Co-led inpatient group therapy and parent support groups. Involved in the education and training of psychiatric residents and medical students. Consulted regularly with community care providers. Coordinated comprehensive discharge planning. From 1993-1995, supervised social work staff on the inpatient psychiatry and intake services. Coordinated schedule of interdisciplinary admissions, staffings and team meetings. Represented Department of Social Work on hospital planning and programming committees. Coordinated, monitored and analyzed department Quality Assurance/Improvement program.

Riverside Methodist Hospital, Columbus, OH

February 1988 - June 1993 (Contingent)

Psychiatric Social Worker/Emergency Department

Completed comprehensive psychosocial assessments and mental status exams of persons presenting with acute mental illness. Evaluated need for inpatient psychiatric hospitalization or alternate disposition. Provided assessment and coordinated resources for victims of rape, domestic violence and child abuse.

Franklin County Children Services, Grove City, OH

September 1987-November 1989

Child Welfare Caseworker

Duties included supervision, certification and re-certification of foster families, teaching and demonstrating intervention techniques, positive discipline, and other parenting skills, and investigating state rule violations. Carried caseload of 15 families with children in foster homes. Developed and implemented in each case a comprehensive plan for parent-child reunification. Delivered professional testimony in temporary and permanent court custody cases. Promoted to Child Welfare Caseworker III in April 1988. Additional duties include covering in supervisor's absence, various administrative duties, and management of high-risk cases.

St. Vincent Children's Center, Columbus, OH

November 1986 - September 1987

Activity Specialist (16-40 hours per week)

Activity Specialist in daytime treatment program for 6-12 year old children with severe behavioral handicaps. Responsible for behavior management and modification; teaching living skills and planning activities.

September 1986 - June 1987

MSW Field Placement

Worked with interdisciplinary treatment team, intake program, and an adaptive behavior group. Responsible for the direct treatment of small caseload of children and their families. Proposed, developed and co-led a treatment group for 6-10 year old girls.

Training Center for Youth, Columbus, OH

January 1986 - June 1986

MSW Field Placement

Worked with adolescent male delinquents in this Ohio Department of Youth Services facility. Provided primary treatment for small caseload, developed and co-led an adaptive behavior/values clarification group for felony offenders.

PUBLICATIONS

An ARC-Informed Family Centered Care Intervention for Children's Community Based Mental Health Programs. Olin SS, Hemmelgarn AL, Madenwald K., Hoagwood KE *Journal of Child and Family Studies* (2015).

A National Action Plan for Workforce Development in Behavioral Health. Michael A. Hoge, Ph.D., John A. Morris, M.S.W., Gail W. Stuart, Ph.D., A.P.R.N., Leighton Y. Huey, M.D., Sue Bergeson, M.B.A., Michael T. Flaherty, Ph.D., Oscar Morgan, M.A., Janice Peterson, Ph.D., Allen S. Daniels, Ed.D., Manuel Paris, Psy.D., and Kappy Madenwald, M.S.W. *Psychiatric Services* (2009) 60:7, 883-887.

TEACHING AND TRAINING

The Ohio State University, College Of Social Work Master of Social Work Program

Course Instructor

1999, 2002, 2003

MSW Student Field Instructor

1997-2000, 2006

The Ohio State University Medical Center

Department of Psychiatry

Clinical Instructor

1995 – 1996

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| December 2005 | North Carolina Council of Community Programs Conference, Pinehurst, NC Provided training in core competencies in delivering effective mobile crisis services. |
| March 2005 | NCCBH National Conference faculty Training topic: Core competencies in a Child and Adolescent Crisis Intervention Program. |
| October 2003 | Georgia Department of MHDDAD As a subcontractor to TAC, Inc., developed and delivered a 1-day training on the implementation of a child and adolescent crisis intervention program. |
| Spring 2003 | The Ohio State University College of Social Work Master Program Course Instructor, 741.04: Crisis Intervention |
| September 2002 | Georgia Department of MHDDAD As a subcontractor to TAC, Inc., developed and delivered a 1-day training on the implementation of a child and adolescent crisis intervention program. |
| Summer 2002 | The Ohio State University College of Social Work Master Program Course Instructor, 741.09: Clinical Practice with Adolescents |
| January 2001 | The Ohio State University, College of Social Work Topic: "Grief and trauma in adolescents" |
| June 2000 | Upper Arlington City Schools Topic: CISM 2-day basic training, (co-presenter) |

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| January 2000 | The Ohio State University, College of Social Work Topic: "Grief and trauma in adolescents" |
| December 1999 | ADAMH Board of Franklin County Topic: "House Bill 71" (Duty to protect legislation) |
| August 1999 | Southwestern City Schools Topic: CISM 2-day basic training, (co-presenter) |
| August 1999 | Findley, Ohio Topic: CISM 2-day basic training, (co-presenter) |
| Winter 1999 | The Ohio State University, College of Social Work Master Program Course Instructor, 741.09: Clinical Practice with Adolescents |
| June 1998 | The Ohio State University, College of Social Work Topic: "Adolescent Psychopathology" |
| April 1998 | Franklin County Juvenile Detention Facility Topic: "Interventions with Suicidal Youth" |
| February 1998 | ADAMH Board of Franklin County Topic: "Trauma and Crisis Intervention" |
| April 1998 | Franklin County Board of MR&DD Topic "Community Mental Health" |
| February 1996 | Ohio State University Department of Psychiatry Topic: "Working with the Appalachian Patient" |
| April 1994 | Ohio Society of Clinical Social Workers Topic: "Mood Disorders in Children" |
| February 1994 | Ohio State University Department of Psychiatry Topic: "Working with the Appalachian Patient" |
| April 1993 | Ohio Society of Clinical Social Workers Topic: "Adopting Older Kids with Mental Illness" |
| March 1993 | Ohio State University Department of Psychiatry Topic: "Short Term Therapeutic Crisis Intervention for Families and Children" |
| March 1993 | Ohio State University Department of Psychiatry nursing staff Topic: "When to Involve Child Protection Services/Impact on Families" |
| February 1992 | Columbus Public Schools Topic: "Separation Anxiety Disorder in Children and Adolescents" |
| February 1992 | Ohio State University Department of Psychiatry Topic: "Working with the Appalachian Patient" |

July 1991

Ohio State University Department of Psychiatry

Topic: "Short Term Therapeutic Crisis Intervention
For Families and Children"

EDUCATION

Master of Social Work - 1987

The Ohio State University, Columbus, Ohio

Bachelor of Arts in Sociology - 1985

Miami University, Oxford, Ohio

LICENSURE AND CERTIFICATION

Licensed Independent Social Worker

State of Ohio, License I-4332S

EMDR: Level I and Level II trained. Advanced training in EMDR with children and adolescents.

Critical Incident Stress Management

Received Basic, Advanced and Youth-Specific training in CISM through the International Critical Incident Stress Foundation.