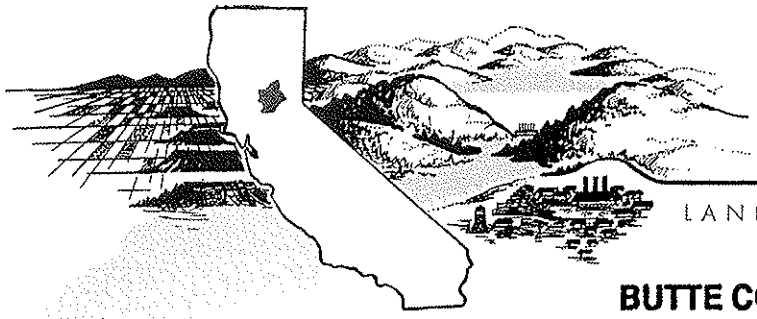

Butte County

LAND OF NATURAL WEALTH AND BEAUTY

BUTTE COUNTY DEPARTMENT OF BEHAVIORAL HEALTH

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August 17, 2010

FILED
Superior Court of California
County of Butte
AUG 18 2010
Kimberly Flener, Clerk
By _____ Deputy
FILED

Honorable Judge Steven J. Howell
Superior Court of California
County of Butte
One Court Street
Oroville, CA 95965

RE: Grand Jury Response

Dear Honorable Judge Howell:

This letter is in response to the findings and recommendations contained within the Grand Jury Final Report 2009-2010.

FINDINGS

F1. The response to the report of the 2008/2009 Grand Jury from the Butte County Board of Supervisors, the Butte County CAO, and the first Department of Behavioral Health (DBH) Interim Director each stated that the Department of Behavioral Health Medical Director position was anticipated to be filled by November 2009. Recruitment was initiated in November 2009 but was suspended within three months without filling the position.

The respondent disagrees with this finding. DBH has engaged in active recruitment to fill the Medical Director position utilizing 15+ publications, websites, radio stations, and informal networking at regularly scheduled meetings of the California Mental Health Directors Association (CMHDA). The original salary for the Medical Director position, established through a comparison study, proved to be insufficient to attract viable candidates. Suspension of active recruiting for 3 months took place pending approval by the Board of Supervisors for a

needed salary increase. Active recruitment was re-initiated immediately after Board approval. To date, DBH costs for recruiting both the Medical Director position, as well as ongoing recruitment for psychiatrist positions, have exceeded $40,000. A recent addition to recruitment activities involves a nationally based web-search system for candidates.

F2. The Medical Director position description as it is written does not carry the authority or responsibility to make clinical decisions.

The respondent disagrees wholly with this finding. The Medical Director job description/specification clearly demonstrates authority and responsibility to make clinical decisions:

Under direction of the Behavioral Health Director, and "in collaboration with the Assistant Director of Clinical Services, **plans, organizes and manages the medical services** component of the Butte County Department of Behavioral Health; **coordinates and supervises the medical practice and all clinical services components** of all staff and contracted psychiatrists; oversees the compliance of mental health medical providers and services with applicable community standards of care, State and Federal laws and other regulatory requirements..."

F3. Butte County did not recruit to fill the position of the Permanent DBH Director during the two years while there was an interim director for DBH.

The respondent neither agrees nor disagrees with this recommendation. It is outside the scope and responsibility of the Department. The County Administrative Officer retains the authority to make decisions regarding appointment of Interim Directors and/or recruitment of permanent Directors.

F4. The first Interim Director served under an open-ended contract.

The respondent neither agrees nor disagrees with this recommendation. It is outside the scope and responsibility of the Department. The County Administrative Officer retains the authority to make decisions regarding appointments of Interim Directors and/or recruitment of permanent Directors.

F5. The DBH had to adjust to the first and the second Interim Directors, and will have to adjust again when a permanent Director is hired, continuing the instability of the department.

The respondent partially disagrees with this finding. DBH has had two Interim Directors, both of whom were well received by direct service and administrative staff. Both came to the

Department with years of experience as former Behavioral Health Directors, and contributed greatly in assisting the Department through budget challenges and low morale. In addition, both have contributed significantly to improving and streamlining collaboration between administration and direct service staff. The respondent disagrees with the general characterization that the necessary challenges and changes the Department has made, and continues to make, creates instability. The financing and treatment environments of public behavioral health service continue to experience significant turmoil and change. The Department is committed to meeting these many challenges. The appointment of a new permanent Director is much welcomed, and the vast majority of feedback from staff has been positive.

F6. Documents requested from administrators were often provided to the Grand Jury after long delays and the material often was not what the Grand Jury requested.

The respondent disagrees wholly with this finding. The majority of the documents requested were available and submitted promptly. Some documents requested required extensive data collection and staff time for preparation. DBH worked diligently to make these reports available to the Grand Jury in a timely manner, while balancing the very real need of completing significant daily departmental demands.

F7. Medical staff is often unable to obtain fiscal and statistical data.

The respondent disagrees wholly with this finding. The Department has made concerted and consistent efforts to honor all reasonable fiscal and statistical data requests from staff. DBH currently has a variety of reports that are easily accessed. Some data extraction, however, requires new reports/queries to be generated, and these take staff time to develop. The Department continues to develop its capacity to gather increased data that will generate reports on demand. In addition, the department created a Systems Performance Evaluations Manager, and team, dedicated to data collection and development of outcome reports. An organized format for data requests is in development to track and monitor special requests for information requiring significant staff time, and to prevent duplicative work.

F8. The administrators sometimes failed to provide the correct financial reports as requested by the Grand Jury, even though the correct reports have the titles the Grand Jury used in making the request.

The respondent disagrees wholly with this finding. DBH provided all requested financial reports promptly. DBH acknowledges that one report requested concerned a specific contractor. The report was not forth coming secondary to the contractor failing to submit necessary information. Failure to provide this particular report was not an intentional act of holding back information from the Grand Jury. The Department is currently conducting an independent audit of this contractor in order to gain a full understanding of their financial practice.

F9. The DBH amends contracts after service has been provided and writes them to cover the invoices submitted by and paid to the contractor.

The respondent disagrees wholly with this finding. The Department and the County have a policy against this practice. All contracts and amendments to contracts are completed prior to submission of payment to contractors for services rendered. Some essential services, such as psychiatric care, may continue as contracts with individual psychiatrists are renewed. However, no new contract services are provided prior to final approval through the proper authorities.

F10. Several psychiatrists on staff and under contract are ready to retire and there is a critical shortage of psychiatrists.

The respondent agrees with this finding. Concerted efforts to recruit psychiatrists continue.

F11. Mentally ill patients in crisis often wait excessively long periods at hospital emergency rooms before the DBH will accept them at the Crisis Stabilization Unit.

The respondent partially disagrees with this finding. Some individuals in crisis spend excessively long periods at hospital emergency rooms waiting for inpatient hospitalization. Prolonged wait times at the emergency rooms can result from: a need to obtain necessary medical clearance for placement to an appropriate level of care; lack of capacity at the DBH Psychiatric Health Facility (PHF), or; finding/coordinating placement to another facility in the State. The findings that wait times are related to the failure to accept clients onto the Crisis Stabilization Unit (CSU) is incorrect. When appropriate, there are processes in place for rapid transfer to the CSU on a voluntary basis.

An additional effort to decrease psychiatric crisis impact on emergency rooms includes the Crisis Intervention Team (CIT) program. The CIT program was initiated by the Behavioral Health Advisory Board and is an active collaboration between law enforcement, BCDBH, and local hospitals including Enloe. The first 40 hour training was full to capacity and has resulted in law enforcement officers who feel more confident in working with our consumers and who through the CIT program have developed strong working relationships with BCDBH Crisis Stabilization (CSU) and PHF staff members. Both law enforcement and BCDBH staff report that this has resulted in more direct admissions to the CSU and less mentally ill patients dropped at the ER's.

BCDBH is exploring additional ways to partner with Emergency Departments throughout the County to provide crisis evaluations in a timely manner.

F12. Patient transfers out-of-county are excessive, very costly, and increasing in number.

The respondent partially disagrees with this finding. In fiscal year 08/09, the Department spent $214,784 on Youth out-of-county hospitalization and $410,409 on Adult. $288,838 and $469,937 respectively was spent in fiscal year 09/10. DBH acknowledges this is a significant cost, but disagrees with the finding that either the numbers and/or costs are excessive. The Department acknowledges that out-of-county hospitalization is not ideal, is to be avoided if possible, but is nevertheless sometimes necessary. In addition, the Department receives reimbursement for many of the services provided for out-of-county hospitalizations.

F13. Often children and youth Medi-Cal patients are sent out-of-county, which reduces the quality of their care and is more expensive for the County.

The respondent agrees with this finding. There are no youth inpatient hospital beds in Butte County. Department staff makes every effort to utilize local alternatives to hospitalizing when appropriate. DBH fully acknowledges that avoiding out of county hospitalization is a priority. One local alternative is Therapeutic Behavioral Health services (TBS), a one-on-one intensive intervention service designed to prevent any out-of-home placement - whether to foster care, group homes, or psychiatric hospitals. Through concerted efforts in streamlining TBS referral processes, and general community education and outreach, delivery of this service has increased dramatically in the past fiscal year. Note: a cost analysis was conducted regarding the specific hospital alternative program for youth - Hope Cottage (see F14). It was determined that the Department actually spent more on in-county alternatives than out-of-county alternatives when viewed from a cost per unit perspective.

F14. Hope Cottage is a resource, that if fully and properly utilized, has the potential of serving the needs of youth better than sending them out of County for psychiatric hospitalization. It would save money for the County each year.

The respondent disagrees wholly with this finding. The Department acknowledges that the Hope Cottage program provided needed services to youth. In review of the data, however, the program cannot be deemed a cost effective alternative (see table below). In an effort to provide both cost effective and clinically appropriate hospital alternative, the department has issued a new RFP. A new contractor has been selected by an 8 member review panel to provide hospital alternative services for youth in FY 10/11.

06/2//09-02/28/10

	Hope Cottage	**Hospital**
Average LOS	51.71	9.9
Average Cost	$22,730.75	$5,171.66

F15. Hope Cottage is fully operational but funded for only three of its six beds.

The respondent disagrees wholly with this finding. The Hope Cottage program was fully funded for 3 beds as originally designed. The original design created by Hope Cottage included filling an additional three beds through placement by Department of Employment and Social Services. Analysis at year end revealed that the original program design ultimately proved less cost effective than proposed.

F16. Transportation for out-of-county hospitalizations is an expensive yearly cost to the County that could be used to fund in-county alternatives; yet the costs are not separately tracked in the budget, thus making it difficult to know exactly how much money might be available.

The respondent partially disagrees with this finding. The Department acknowledges the high cost of transportation and has taken steps to reduce whenever possible. A Mental Health Services Act (MHSA) program is under development which will utilize staff, consumers and county vehicles to transport clients to and from out of county hospitals when necessary, and it is anticipated this will have a significant impact on decreasing expenses. The Department does track the cost of transportation as an expense account within the Auditor's system and the Department's accounting system. In fiscal year 09/10 it was necessary for staff to manually separate the out-of-county costs from in-county costs. In fiscal year 10/11, it will be done electronically.

F17. The contract for the review of the DBH fiscal operations was excessively costly and ultimately did not result in an "accepted" final report.

The respondent partially disagrees with this finding. Based on the prior year's Grand Jury response, the Interim Director requested an outside fiscal review. The reports were accepted by the Department and did contain both positive and useful information. The respondent believes the Grand Jury misinterpreted the cost of the contract secondary to it crossing into different fiscal years. The actual encumbrance for one first fiscal year was $5,000, not $14,875. Total expenditures were specifically $4,900.39. The Department has received several reports on specific fiscal areas of DBH, but did not receive one comprehensive final report. It was determined to be an unnecessary additional step and not cost effective as the specific fiscal area reports covered issues of concern.

F18. The security, storage, and backup of the data that is produced and used by the DBH are insufficient. Plans exist to build an improved system, but the DBH plans do not take advantage of the existing comprehensive Butte ISD system.

The respondent disagrees wholly with this finding. In May of 2008, DBH IT completed the purchase, installation and implementation of a primary Storage Area Network (SAN) in Chico, and a failover (for disaster purposes) Storage Area Network (SAN) in Oroville. These SANs hold numerous "File Server" partitions as well as the Behavioral Health Information System (Avatar) databases. Prior to implementation of the SAN, DBH IT reviewed and discussed the project plan with Butte ISD and received their approval. Further, in 2008, DBH implemented a robust, multi-level backup and archive system ensuring long term data and file archives, data integrity and continuity, and disaster response management. The Butte ISD system was unable to provide adequate storage, failover, and disaster continuity needed by DBH.

F19. The Avatar electronic health record system is being blamed by DBH administrators for not being able to provide Client and Services Information (CSI) reporting data to the California Department of Mental Health as required.

The Respondent partially disagrees with this finding. A number of factors led to the difficulties in reporting CSI data to California Department of Mental Health.

- Conversion – Due to lack of appropriate guidance from the new Avatar system vendor, the data import from the previous legacy system, Insyst, was not complete or sufficient to meet all CSI reporting requirements. This necessitated a large amount of post-conversion work on behalf of DBH administrative staff.

- Netsmart Implementation Staff – The Project Manager initially assigned to by Netsmart to assist DBH in its implementation lacked the necessary experience and knowledge of be effective. It was not until well into the implementation (August 2008) that DBH was able to negotiate with Netsmart to assign a different, qualified implementation/project manager.

- Application Version Issues – The initial version of the CalPM module of Avatar was "CalPM 2005". This version had numerous "bugs", including process and logic flaws, and these created significant implementation difficulty, not least of which was an inability to report CSI effectively. Further, while a number of the bugs, process or logic flaws were known to Netsmart, they could only be fixed by upgrading to a newer "CalPM" module which Butte did not have at the time. At this same time, the State changed their claiming method with the transition to Short Doyle Medical Phase II. It was necessary and beneficial for DBH to continue running CalPM 2005 due to complex billing/claiming issues that existed. Many counties were unable to bill/claim for an extended period of time. Butte County, by contrast, was able to continue to perform critical business billing/claiming and revenue generation by continuing to use the older version. In early 2010, DBH was able to solve the billing/claiming issues and migrate to "CalPM 2007". This has alleviated at least some of the problems of the previous version with regard to CSI data management and reporting system.

- Current Status – With the application version upgrade, and significant work by DBH IT and administrative staff, DBH has successfully resolved many issues preventing proper

CSI reporting. Butte IT staff has worked with representatives at the California Department of Mental Health (DMH), and DBH is now up to current state reporting requirements and timeliness. DMH has indicated that it will soon issue an updated report regarding statewide County CSI reporting status, and it is anticipated this will reflect Butte's compliance.

F20. The DBH converted to the Avatar electronic health record system and stopped using its prior system prematurely, creating a lack of ready access to vital information for CSI reporting.

The Respondent partially disagrees with this finding. At the time, DBH believed that the implementation date was appropriate. Retrospectively, we now know that Netsmart's California version of Avatar was not fully California compliant. DBH has continued to work through many challenges, including reduced staff, and successfully maintained one of its highest administrative priorities: claiming to the State to bring in revenue. Delays in CSI reporting have been addressed above.

F21. The DBH IS staff does not work closely or coordinate with the Butte ISD, and does not take advantage of experienced staff, expertise, and leadership of the Butte ISD.

The Respondent disagrees wholly with the finding. DBH IT personnel have a long history of working collegially with Butte ISD. DBH IT routinely leverages resources and knowledge of Butte ISD staff and infrastructure whenever possible.

The specialized business and service needs of DBH are unique, and the department is fortunate to have a highly motivated and trained team of IT professionals with extensive knowledge and experience regarding those specialized needs. DBH IT leadership is dedicated to developing IT staff skills and capabilities that help support the unique technological demands of the department and its customers. DBH believes strongly that this results in a much higher level of service than could be provided by a remote team such as Butte ISD. In addition, focus groups and general feedback indicates that the vast majority of DBH staff strongly believe that DBH IT provides a high level of quality service and support, and that this would likely be compromised be using a more remote team such as Butte ISD, particularly in the areas of front-line or help desk support. DBH IT continues to work closely and collaboratively with Butte ISD on a number of projects and needs that overlap areas of responsibility, and will continue to adhere to requirements and responsibilities that are the purview of Butte ISD.

F22. The DBH has been successful in obtaining publicly funded state and federal grants.

The respondent agrees with this finding.

F23. Unnecessary and expensive out-of-town trips have been made and paid for by tax - supported, publicly funded state and federal grants.

The Respondent disagrees wholly with this finding. The cost of the event mentioned in the Grand Jury report is in error. The actual Salary and Benefit costs were $3,851, and not $19,994 as indicated in the Grand Jury report. Actual expenditures were fully funded by SAMHSA and Medi-Cal revenues received for direct services provided in relation to the event. In addition, DBH received the following response from the Substance Abuse Mental Health Services Administration (SAMHSA), the Federal agency supporting this activity, when asked if they believed the event was appropriate: Susan Stromberg, Project Manager from SAMHSA replied in an email on July 7, 2010:

"You are correct – we are very satisfied/impressed with the work that you have done in Butte County with Connecting Circles of Care!

We support field trips for youth when they fit in to the goals of the system of care. As part of the grant, you are required to develop a youth group and promote youth leadership. Incentives are usually part of service plans, and are used to teach youth acceptable behaviors and coping skills. A field trip is an appropriate incentive to support the youth within the system of care as they make progress and meet their goals.

Therefore, we support the use of grant funds to take the youth on a trip to see a professional basketball game. A field trip can be an incentive for youth for attending their appointments and for meeting the requirements given to them by their counselors. It is also a way of acknowledging/rewarding their progress at school. A field trip, in itself, offers opportunities for working on mental health issues. There is the responsibility of being a part of a group and looking after other youth, behaving appropriately in a public environment, and working on socialization. As you know, youth with mental illness often have problems coping in places with many people.

Also, as you know, one of the main premises of systems of care is that services are strength-based. Youth with mental health challenges often have low self esteem, which then permeates into the different areas of their lives. A field trip such as this will help youth feel good about themselves, which will certainly help improve their functioning at home, at school, and in the community.

A field trip to a professional basketball game is an acceptable use of grant funds."

F24. The DBH Advisory Board often takes direction from the DBH administrators instead of taking the initiative to pursue their full advisory function as provided for in the California Welfare and Institutions Code § 5604.2.

The respondent disagrees wholly with this finding. The DBH Advisory Board is an independent body and does not take direction from the DBH administrators. The Department

works closely with the DBH Advisory Board and has included and sought feedback from their members in DBH Advisory Board meetings, Leadership Team meetings, Quality Assurance Committee meetings, Budget Workgroup meetings, and MHSA stakeholders meetings.

F25. This is the second consecutive Grand Jury to have concerns about the operations of Butte County Department of Behavioral Health.

The respondent agrees with this finding. An effort has been made by the Department for the past year to continue to enhance transparency, and to educate staff and the community regarding the Department's operations. These efforts have assisted in reducing misconceptions concerning how budgets are developed, or how funding is allocated. The response by staff, and the community, has been well received. The Department is committed to an ongoing process of communication, transparency, and fiscal accountability to all stakeholders.

F26. Among the administrators there seems to be a lack of value for the medical component of mental health treatment.

The respondent disagrees wholly with this finding. The Department has consistently made it a priority to retain and seek medical staff as demonstrated by: County psychiatrist salaries have been increased during significant overall budget reductions; continuous and aggressive recruitment for hiring new psychiatrists, and; the creation and aggressive recruitment of a Medical Director position. Until a Medical Director is retained, the Department Director will work closely with the currently elected Chief of Medical Staff to enhance the collaboration among all parts of the Department.

RECOMMENDATIONS

R1. Recruit for and fill the Medical Director position without further delay.

This recommendation has been implemented. DBH has been actively recruiting the Medical Director and psychiatrist positions in 15 publications, websites, and radio stations with a cost over $40,000. Additional efforts include a contract with a national websearch firm, outreach to Residency programs, and participation in upcoming "job fairs" sponsored by medical conferences in California and nationally.

R2. Write the Medical Director position description to carry the authority and responsibility to make the final clinical decisions.

This recommendation will not be implemented. DBH services are delivered by a multidisciplinary treatment team. Providing sole discretion to one individual for all clinical decisions would not only undermine the multidisciplinary approach, it would reflect a "top down / authoritarian" management style that has been soundly rejected in the past by both current administrators and line staff. The medical staff should work collaboratively with the multi-disciplinary team to develop appropriate plans for treatment, and assist with decision making in an ongoing manner. The Medical Director will be responsible for monitoring the practices of the medical staff, and for providing consultation and assistance to all treatment staff in a collaborative, multi-disciplinary model. The Behavioral Health Director has full operational responsibility for the Department.

Further, as previously noted the Medical Director job description states the position will work under the administrative direction of the Behavioral Health Director and "in collaboration with the Assistant Director of Clinical Services." Further duties include "directs, evaluates, plans, establishes and implements the medical services component and all clinical services of the Mental Health Department; participates in the coordination of services across county departments and agencies; provides medical direction and consultation to all mental health programs and consultation to its contracted agencies, particularly in the areas of quality improvement, medication monitoring, and peer review."

R3. Develop a policy to initiate the recruitment for a permanent director immediately upon notice that a vacancy will occur in the position.

The respondent neither agrees nor disagrees with this recommendation. It is outside of the scope of responsibility of the Department. Only the Human Resources Department can establish policy regarding recruitment. Of note however, is that a permanent Director has been hired and began her position with the Department on June 7, 2010.

R4. Develop a policy to hire interim directors only with end-dated contracts.

The respondent neither agrees nor disagrees with this recommendation. It is outside of the scope of responsibility of the Department. Only the Board of Supervisors can hire and set the terms of a contract for an Interim Director.

R5. The recruitment for a permanent director should not be suspended while there is an Interim Director.

The respondent neither agrees nor disagrees with this recommendation. It is outside of the scope of responsibility of the Department. It is the County Administrative Officer who has the authority to make decisions on whether to recruit for a permanent Director while there is an Interim Director.

R6. Provide training in fiscal transparency for the DBH administrators.

This recommendation will not be implemented. It is not warranted and/or reasonable. DBH must, and will continue to, follow all federal and state laws, as well as all County policies, with regard to releasing financial data - unless restricted by privacy laws.

In order to further increase fiscal transparency, the Department developed a budget workgroup consisting of DBH line and medical staff, youth and adult consumers, the Leadership team, administrative support staff, Behavioral Health Advisory Board members, and contractors. The Interim Director invited volunteers from all areas to join this group, and a continuing task force of 25 members continues to meet regularly.

This workgroup is being educated on all facets of the behavioral health budget including funding streams, costs of different programs and services, leveraging funds, how a budget is developed, as well as the impact that budget reductions have on programmatic decisions. The DBH staff takes information from each meeting back to their worksites which increase fiscal transparency. This workgroup will make recommendations to the Director regarding potential programmatic changes as they relate to funding and service needs.

Behavioral Health financing is complex and some standardized reports require special knowledge to understand or interpret. In order to expand the knowledge base, fiscal staff has provided mental health financing training to program managers and supervisors.

R7. Develop and adhere to a written policy for transparency with regard to fiscal and statistical data.

This recommendation requires further analysis. As noted above, DBH must follow all federal and state laws, as well as all Butte County policy, that address the release of financial and statistical data, including the very real need to adhere to privacy laws. In addition, DBH must determine if the venue of a written policy is best suited to address the somewhat subjective nature of transparency and its achievement. DBH will conclude its analysis by the end of October, 2010, and, if indicated, initiate the creation of a new policy.

R8. The administrators should produce, refer to, and discuss reports using only standardized accounting terminology.

The recommendation will not be implemented. It is not warranted and/or reasonable. While the administrators produce reports using standardized accounting practices, only discussing and referring to the information on the reports with clinical management and line staff would be in direct conflict with the transparency that the Department supports.

R9. Develop a policy that does not allow contractors to provide or bill for services unless there is a current and complete contract in effect.

The recommendation has been implemented. Both the County and the Department have current policies preventing contracts to provide or bill for services unless there is a current contract or amendment in place. In accordance with Butte County policy, any new contract, amendment, or any other contract changes needed by the Department, that cause the total contract price to exceed the Department's delegated purchasing authority, require approval by the Board of Supervisors. An exception may occur, with CAO approval, for necessary ongoing medical services. A treatment provider may continue to provide services while a contract is in process.

R10. Develop and implement an aggressive and creative plan to hire psychiatrists.

This recommendation has been implemented. DBH has been actively recruiting the Medical Director and psychiatrist positions in 15 publications, websites and radio stations at a cost of over $40,000.

R11. Establish relationships with the local hospitals that will ensure an efficient transition for mentally ill patients who are in crisis from emergency rooms to the Crisis Stabilization Unit.

This recommendation has been implemented. In addition, the Department is working closely with local hospitals and law enforcement to develop rapid transitions from emergency rooms for mentally ill patients requiring hospitalization or crisis stabilization services. The Department has been meeting with a local hospital on a regular basis to discuss co-locating DBH programs, including the Crisis Stabilization Unit, as a partnership to ensure efficient transitions.

R12. Make it a priority to keep youths and adults in Butte County when they need to be hospitalized for mental illness.

This recommendation has been implemented. It has always been, and will continue to be, a priority to provide services to both youth and adult clients within Butte County in the least restrictive environment.

There are no youth inpatient hospital beds in Butte County, and there are limited beds within Butte County for adults. Although DBH staff make every effort to utilize local alternatives to hospitalization for both youth and adults as appropriate (e.g. Crisis Stabilization Unit, TBS, etc.), the safety of clients must be the top priority when clients pose a danger to themselves or others.

R13. The department should set a priority on the establishment of more treatment facilities within the County and utilize current facilities to full capacity.

This recommendation is implemented with regard to utilizing current treatment facilities to full capacity. The DBH PHF has been, and will continue to be, utilized to full capacity. Adults needing hospitalization are sent out-of-county only when a bed on the PHF is not available. As noted previously, DBH is working closely with a local hospital with regard to co-locating Crisis Services, etc., to minimize the need for out-of-county placement. DBH has initiated a residential long term facility in Paradise designed to reduce the need for long term placement out-of-county. As noted previously, an RFP has been initiated to continue a hospital alternative program for youth.

This recommendation requires further analysis with regard to setting a priority for the establishment of new treatment facilities. As seen in the Hope Cottage Hospital Alternative program, it is vital that DBH continue to analyze data in order to best balance specific treatment needs, capacities, and costs. Analysis of treatment needs and available funding streams is ongoing. As areas of need are identified, and funding streams made available, DBH will initiate future RFP's that address the creation of programs that meet treatment needs of our community.

R14. Fully fund the six beds at the Hope Cottage youth facility.

The recommendation will not be implemented. It is not warranted and/or reasonable. The Hope Cottage program did provide an array of services to youth, but review of the data has revealed that the program design was not a cost effective alternative to youth at risk of hospitalization. Increasing its capacity to six beds would not resolve the fiscal and programmatic challenges which were identified with this program design. In an effort to provide a cost effective and clinically appropriate program the department has issued a new RFP. A new contractor has been selected by a multi-disciplinary review panel and contract negotiations will begin immediately to ensure a timely start-up for services.

R15. Develop a separate expense account number for out-of-county transportation of patients.

The recommendation has been implemented. DBH has an audit system that tracks transportation costs, including those incurred related to out-of-county placement.

R16. Utilize the existing Butte ISD system for security, storage, and backup of the data that is produced and used by the DBH.

The recommendation will not be implemented. It is not warranted and/or reasonable. DBH has a fully functional I.T. system in place to handle security, storage and backup of data, and this has been in place prior to the 2009/2010 Grand Jury being seated. As noted above, DBH has no need to use Butte ISD systems. Further, DBH believes that a full transfer of I.T. services to Butte ISD would not meet the specialized needs of the department and its staff (see Findings 18 response). In addition, DBH business needs require a 24/7 IT support model. The proximity of server and network equipment is key to the provision and continuation of the department's critical business needs.

R17. Comply with the California Department of Mental Health CSI reporting requirements in a timely manner.

The recommendation has been implemented. DBH Administrative and IT staff, working closely with the Netsmart vendor and DMH representatives, have successfully brought DBH into full CSI reporting compliance.

R18. The DBH should coordinate information systems and technology with the Butte ISD to take advantage of experienced staff and share IS/IT expertise.

The recommendation has been implemented. DBH IT work closely with Butte ISD on projects or needs that overlap in responsibility, or that are the operational domain of Butte ISD (See Finding 21). In addition, DBH IT is willing to provide Butte ISD, or any other County department, with experienced staff and IT expertise when requested.

R19. The future expenditures on out-of-county group trips by the publicly-funded state and federal grant programs should be eliminated.

The recommendation will not be implemented. It is not warranted and/or reasonable. DBH will continue to utilize available funding for appropriate clinical needs, and positive clinical outcomes, in accordance with state and federal guidelines. The out-of-county group trip noted by the Grand Jury is just one example of a clinically sound use of funds that is not only in accordance with state and federal guidelines, it was fully supported by the specific grantors.

R20. The DBH Advisory Board should pursue their full advisory function as provided for in the California Welfare and Institutions Code § 5604.2.

The recommendation has been implemented. The DBH Advisory Board functions as stipulated by W&I Code 5604.2. Advisory Board members have requested assistance to move them in the direction of becoming more effective in their function, and to clarify for Board members the mission and purpose of the Board. Further training will be provided to Board

members on the proper function and conduct of an Advisory Board including HIPPAA, Confidentiality and Privacy issues, Board structure and process, By-Laws development, and other topics at the members' request.

R21. The DBH administration should structure and operate its programs so as to reflect a high value for the medical component of mental health.

The recommendation has been implemented. The value of medical services and consultation in the delivery of behavioral health treatment is indisputable. However, as Community Behavioral Health, our mission as a Department includes many services and treatment modalities beyond medications. Mental illness is a medical issue; it is also an emotional, relational, social, and community issue. The impairments and challenges presented to those families and individuals affected by severe and chronic mental illness must be treated from a holistic orientation including various social supports, training in activities of daily living, education/employment, recreation, socialization, etc. Medication services are one of the essential tools in an individual's recovery. Medication services alone do not fully address the needs of our consumers, their families, or the community. The Medical Staff are essential partners and have medical responsibility for their patients. They also have extensive training and knowledge which could greatly benefit all treatment staff, and consumers, in decision making. However, as a collaborative multi-disciplinary team, all staff providing treatment and services to an individual or family must have input into planning. As a consumer centered program, the recipients of treatment must become partners in their own recovery. None of these statements are inimical to the medical staff; rather, it is a misunderstanding and misapplication of the term "recovery orientation" which may have lead to some of the conflict between medical staff, administration, and others. Work to fully develop a collaborative and cooperative understanding of community mental health treatment from a recovery and resiliency orientation is still underway; the medical staff must be a part of that process.

The overarching mission of public mental health services has been delineated by longstanding policy. New initiatives toward recovery and resiliency have been captured in the Mental Health Services Act fundamental concepts.

The Mission Statement of the California Mental Health Planning Council from 2003 begins:

The mental health constituency envisions a society in which persons of all ages, ethnicities, and cultures who experience serious mental illness or serious emotional disturbance receive high quality, culturally and linguistically competent, and effective services from the mental health system. As a result of the services, support, and rehabilitation they receive, these persons are able to lead happy, productive, and fulfilling lives.

The mission of California's public mental health system is to enable all individuals, including adults and older adults with serious mental illnesses and their families and children with serious emotional disturbances and their families, to access services from a seamless system of care. These services will assist them, in a manner tailored to each individual, to achieve their personal goals and optimal recovery and to develop skills that support living the most constructive and

satisfying lives possible in the least restrictive environment. The mental health system shall help children achieve optimal development.

The foundational concepts of the Mental Health Services Act (MHSA, Proposition 63), which "must be embedded in all stages of development and implementation of MHSA programs" are:

- Community Collaboration: Community collaboration refers to the process by which various stakeholders including groups of individuals or families, citizens, agencies, organizations, and businesses work together to share information and resources in order to accomplish a shared vision.

- Cultural Competence: Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumers/peer/family providers, and professionals that enables that system, agency or those consumer/peer/family providers, and professionals work effectively in cross-cultural situations.

- Client/family driven mental health system for older adults, adults and transition age youth and family driven system of care for children and youth: Adult clients and families of children and youth identify their needs and preferences which lead to the services and supports that will be most effective for them.

- Wellness focus, which includes the concepts of recovery and resilience: Recovery refers to the process in which people who are diagnosed with a mental illness are able to live, work, learn, and participate fully in their communities.

- Integrated service experiences for clients and their families throughout their interactions with the mental health system: This means that services are "seamless" to clients and that clients do not have to negotiate multiple agencies and funding sources to get critical needs met and to move towards recovery and develop resiliency.

As the Department develops and works toward our future goals, these directives and concepts will form the foundation of our decisions. We believe that they encompass the philosophy which will guide the solutions to many of the concerns expressed by the Grand Jury.

Sincerely,

Anne Robin, MFT
Director