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LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH GOALS AND OBJECTIVES - PRIORITIES FOR THE '80's

In January 1979, the then newly formed Los Angeles County Department of Mental Health presented to all staff the prioritized objectives of the department. Our objective for Los Angeles County, as stated then, continues to be-to establish a comprehensive and coordinated single system of care with a full range of services in each Region at multiple locations, available and accessible to all the residents of the County, primarily focusing on the severely and chronically mentally disordered population.

At this time, the Department of Mental Health finds itself in a period of greatly restricted resources and growing demands. Historically, these conditions lead to a dehumanization of all mental health services and a re-institutionalization of the severely ill. Recognizing this, and hoping to avoid these problems, the Department of Mental Health believes that it is essential that we once again clearly articulate the policies, goals and objectives of our treatment programs for the information of the staff and community, and the betterment of our patient care services.

Competency of services is reflected in their state of humanization. Voluntary treatment should replace the involuntary; inclusion of family and close friends very early in the course of treatment must be the rule wherever possible; a comprehensive continuum of services should be available to each patient as appropriate while simultaneously maintaining a single personal contact with the patient (such as a case manager or primary therapist). Substandard and poorly equipped treatment facilities which demean patients, care-givers and the society in general must be upgraded so that the aesthetic surroundings will contribute to the sense of hope and dignity offered to the patient and family.

The matter of continuity of care is central in determining the quality of services which are delivered. The responsibility for assuring well coordinated and appropriate services, provided close to home and in the least restrictive setting, begins with the first mental health staff person contacted and continues for as long a period as services are needed by the identified patient and his/her family. Each District Office and/or contractor admitting a patient to the system from their area of responsibility must, therefore, assure that the needs of the patient are being served regardless of where that patient may

be in the system at any given time. Procedures including Case Management must be clearly articulated to assure that this priority to continuity is implemented.

As a publicly funded and responsible mental health provider, the Department of Mental Health must give its highest priority to those persons most in need and least able to obtain services in other sectors of the society. Thus, the Department's highest priorities are to provide services to those persons (including children, the aged, the handicapped, minorities and the mentally disordered in the justice system) who are severely, acutely and/or chronically ill who are unable to obtain services in the private sector. These individuals are not only in greatest pain, but also are most problematic for their family and friends, the community and society.

The acute inpatient and alternative to hospital services designed for seriously ill children and youth require longer periods of time for effective treatment. These services are excluded from the short-term treatment policy as set forth there which is to be applied to adult patients.

It is also imperative that the system not prematurely turn away persons seeking help before an informed judgment is made regarding the individual's needs and how best to use all available community resources to meet those needs. Thus, the Department has an obligation to provide basic screening and assessment services to any person needing help, but will only be able to provide treatment and rehabilitation services to the groups identified above.

The above principles and priorities, namely the requirement of a humane, responsive service system for the most severely ill members of our society dictate the program priorities and objectives which follow:

I. Crisis and Emergency Services

At the present time acute 24-hour, 7-day week facility-based emergency services are available, either in a hospital setting or non-hospital setting, in at least one location in each Mental Health Region. These services are to be continued and where population, needs, and geography dictate, additional 24-hour, 7-day week emergency services will be developed. However, a mental health system which continues to provide after-hour emergency and crisis intervention services solely within the confines of a hospital-based emergency room only increases the risk and the rate of hospitalization, as opposed to implementing the concept of early and intensive intervention to ensure the utilization of resources other than 24-hour acute hospital-based care.

The availability of after-hour non-hospital-based crisis management mental health services is basic to the following goals:

1. Providing services to specific target populations who are unable to avail themselves of services within traditional working hours, i.e., the single working parent, families in crises, the elderly who may need the assistance of a relative and ethnic minorities whose economic status prevents them from seeking and/or receiving services during traditional working hours.

2. Providing crisis intervention services in a non-hospital based facility with the purpose of exploring, whenever feasible, an alternative to hospitalization for those experiencing acute distress.

3. The development of a support system to law enforcement agencies in the handling of crisis situations.

4. The development of an integrated and well coordinated interagency network of crisis management services, e.g., DPSS, Health Services, 24-hour hotlines, etc.

5. Pre-admission screening and implementation of the gatekeeper concept.

6. More effective collaboration with hospital-based emergency services which currently have little or no after-hour service alternatives for situations which may not require hospitalization.

After-hour service coverage will be provided in a systematic and planned manner. Coverage will be provided for each district through existing resources utilizing rearrangment of resources and staff hours to ensure coverage from 8:00 A.M. to at least 8:00 P.M., Monday through Friday and appropriate coverage during peak hours on Saturdays and/or Sundays. When necessary, services may be consolidated to ensure more appropriate use of resources in the geographical areas of highest need.

After-hour coverage should ensure crisis management capability as well as scheduled treatment activities encompassing the full range of outpatient services. This will ensure the most appropriate utilization of staff time and resources.

Furthermore, after-hour services will include a special linkage to a 24-hour, 7-day a week crisis intervention and evaluation unit with holding bed capability and the availability of on call staff with mobile capability. While the hospital-based emergency remains key to a system of after-hours crisis and emergency services, it should not be the only resource for early and intensive intervention services.

II. 24-Hour Care Services

Hospital services, as well as non-hospital residential treatment programs, comprise an extremely large and important component of the mental health treatment system. Because these services are of vital importance and very expensive, their proper utilization is critical in this time of shrinking resources.

Local acute hospitals, both County-operated and contract, are our most restrictive, intensive, and expensive treatment resources. Therefore, they should be reserved for those patients who are most acutely ill and whose problems can be most quickly resolved in this very intensive setting. Our State hospital resources represent a much larger residential care component which is very important, but costs much less than local hospitals per patient day. At these lower costs, they obviously do not have resources for the most acute patients. These facilities can be most appropriately utilized for the longer stay, more chronically ill patient who has special needs that can best be provided in a State hospital setting and whose illness can be expected to require a somewhat longer period of time to resolve.

There are, as we have spelled out in the Three-Year Plan, a wide array of residential care services which are desperately needed but sparsely available. While the Department will continue its efforts to develop more of these resources, this policy statement concerns the parsimonious use of existing hospital resources. Therefore, in each Region of the County, utilizing existing resources, we will have at least one crisis/emergency intervention unit wherein patients may be held up to 24 hours for careful evaluation and, where possible, resolution of acute conditions. During that period it is anticipated that many crises can be resolved to a point which will allow the patient to return home, to be seen in outpatient care, or to be placed in an alternative therapeutic residential setting. Only those whose problems are not resolved will be admitted to the acute hospital.

Patients should be admitted to one of the State hospitals only after the local acute hospital has thoroughly evaluated the patient and ascertained that in all probability the patient's problem will not be resolved within two weeks hospitalization and that the services of the State hospital are absolutely necessary for the patient's well being. No patient shall be admitted directly to a State hospital from an emergency service. The single regional exception to this policy pertains to patients from San Gabriel Valley Region

who may be admitted to Metropolitan from the CEU at that institution, since Metropolitan serves as the acute hospital for the San Gabriel Valley Region.

The State hospitals have been for the past years the facilities of choice for treatment of L.P.S. type offenders who are under dual jurisdiction for such reasons as: Uniformity of process, consistent case management, and ability to give relevant and consistent feedback to court, law enforcement and mental health. Utilization by that target population shall remain unchanged until a single mental health unit for the mentally ill offenders under L.P.S. is developed in the community.

Proper utilization of local acute hospital services suggests that the mean length of stay in these facilities should be in the range of 10 days with only a limited number of patients staying beyond 17 days. Patients requiring more lengthy hospital treatment should have been transferred to the State hospital system after a much briefer stay.

The implementation of this policy will ensure that all Los Angeles County patients get a proper and complete evaluation prior to being sent to a State hospital. Acute emergencies should not have to be admitted to the State hospital. The average length of stay in community hospitals will in many cases be reduced through the timely transfer of longer stay patients to the State hospitals or other residential treatment alternatives. This will make more short-term acute services available in the community. We recognize that the implementation of this policy will take careful coordination between the Department of Mental Health, the inpatient service providers (including the Department of Health Services), State Office of Mental Health Social Services, and the Public Administrator-Public Guardian. We believe the necessary cooperation will be forthcoming.

III. Acute Day Treatment and Day Rehabilitation & Socialization

At the present time there is a wide array of day treatment, rehabilitation and socialization programs distributed throughout the County provided both by the Department of Mental Health and by contractors. In many cases the roles and responsibilities of these programs have been poorly defined. In assigning our highest priorities to the most severely and chronically ill patients, these programs take on a renewed importance as components of the system's spectrum of care. Acute day treatment programs must be alternatives to acute hospitalization and, therefore, be capable of bringing the full treatment armamentarium to bear on the acutely psychotic patient who may be living independently, with family, or residing in a specialized residential setting.

Those programs that are defined as having a rehabilitative focus must be designed to primarily serve the chronically ill who need supportive services and skill development to enhance their "quality of life" and progress towards independence and self-sufficiency. It will be essential that these day treatment and rehabilitation programs be closely linked, not only with the acute care aspects of the system for referral processes, but also with the community-care facilities where a large part of their clientele will be in residence.

Finally, the socialization and activity programs are designed to provide value and meaning to the lives of the chronically ill who, at this time are unable to benefit from more intensive treatment. Some programs primarily managed and staffed by volunteers should be part of, or linked to patient "self-help groups", community-care homes, and general community support systems. While these programs are expected to be inexpensive, they are quite valuable in assisting the chronically ill to maintain themselves in the community and enhance their well being.

IV. Outpatient Services

Through both contractors and direct provider units, the Department of Mental Health has a large and widely distributed outpatient care system. That system is becoming increasingly stressed by our inability to keep budgetary pace with inflation and/or the necessity that we redirect services to provide more and better care for the severely mentally ill. While it is widely recognized that long term insight-oriented psychotherapy is quite valuable to some mentally ill persons, i.e., those with neuroses and personality disorders, it is expensive and patient gains are slow. On the other hand, it has been shown that a "brief" therapy approach employing time-limited psychotherapy assisted as necessary by medications and other treatment modalities can achieve acceptable results for many patients at less cost. The Department will no longer be able to provide long term psychotherapy, i.e., beyond 10-12 visits, but instead will devote its efforts to short term and brief therapy approaches. It will, of course, be necessary to maintain many chronically ill patients in treatment for much longer periods of time. Many of these individuals will not need intensive therapy but rather medication prescription, monitoring, and supportive services.

The extended hours concept discussed above under crisis and emergency services is quite compatible with this redirection of outpatient services. Extended service hours allow the involvement of parents, family members and other persons critical to the chronic patient's support network and his or her treatment and

rehabilitation. The evening and weekend hours may be utilized for family and collateral visits, group therapy and programs designed to maintain those individuals who have returned to the work force. This operational change in the kind of outpatient care which the Department will offer recognizes that there will be persons needing care (who formerly were treated in the public mental health system) who no longer will receive the quantity of care that they formerly received. While we regret this fact, we believe this is an appropriate prioritization of our resources, since individuals with mild and moderate neuroses and personality disorders are more able to function in society, and have a better chance of receiving services from the private sector than does the severely and chronically ill population. The Department will have to rely heavily on other community resources such as churches, community colleges, and other local agencies to provide assistance to persons who are not sufficiently disabled to meet our criteria for admission.

V. Redirection of Support Systems

The implementation of the new Departmental priorities requires a redirection of our training (or human resources development), community services and quality support efforts.

A. Human Resource Development

The major resource of the mental health service delivery system is the persons providing service. Thus, the Human Resource Development program will also be affected by the overall redirection of program emphasis. Continuing education, inservice training, job exchange, and other approaches must be used to help personnel use existing skills and develop new ones to implement the new program directions. The essential functions must be clearly articulated. Those who are responsible for program management must assess the existing skills of personnel in the system and identify and plan for what is needed so that appropriate educational and training programs will be available to support the changes in program directions.

The objective of the Human Resource Development Program will be to develop staff with the necessary skills to implement this program direction, and to assure that persons studying to acquire professional qualificiations--nurses, psychiatrists, physicians--are trained to inter-relate in a quality community mental health system through experiencing the implementation of such a comprehensive system.

These objectives do not minimize the importance of continuing education in other areas of professional development, but it is not the Department's responsibility to provide programs for its employees which deal with services which are outside the scope of what can be accomplished with the resources of the system.

Volunteers can be used to help augment professional services. Special training and supervision must be made available to them. Professional staff will also require special training to use volunteers and self-help groups effectively.

B. Community Services

Community Services must focus on the community systems which are most involved with the acutely and chronically disordered such as law enforcement, public assistance agencies, community care facilities, and other human service agencies. Community Services will also be particularly important in explaining the revised priorities of the system to the community and to develop increased community support networks for the target groups.

All modalities of Community Services (consultation, education, information, community organization, and outreach) should be focused on problems related to the priority target groups. For example, Community Services must work to develop access for the chronically mentally ill to all of the generic Community Services such as schools, libraries, rehabilitation, housing, and transportation. Consulting with community care facilities, and coordination with private sector physicians and other health practitioners who often serve those facilities, are important community service functions directed to the target population. Likewise, consultation and training for law enforcement officials and coordination of inter-agency activities to assure appropriate efforts to deal with severely disordered clients are essential functions for the Department.

It is also necessary to develop Community Services for defined groups which are at high risk for mental disability, such as abused children, isolated and depressed elderly persons, multiply-handicapped persons, and victims of violence. Such programs might include developing self-help groups, respite care networks, training peer counselors, and parenting training for adolescent mothers in poverty areas or for abusing parents. Care should be taken to use Short-Doyle resources only for carefully selected target problems for which other resources are not available.

There will continue to be certain Community Service programs which assist the overall mental health system to work with other community agencies to promote the efficient use of existing resources and to increase the use of non-Short-Doyle resources to meet the mental health needs of the total community. Public information activities, especially those intended to improve access to underserved groups and to promote community understanding of mental health needs and programs, will be necessary.

C. Quality Support

The Department presently has a quality support system which performs regular site visits to all providers and is also responsible for data collection and analyses. All future site visits will consider in their evaluation of both contract and direct services providers whether or not the goals and priorities articulated above are being carried out. Future site visits will emphasize the appropriate role of the provider in the service delivery system and make recommendations accordingly.

At the present time, the Department is implementing a new data collection system. When fully implemented (the target is January, 1983), the system will provide an extremely valuable tool by monitoring services and accurately determining what services are provided to what populations, in what quantity, and by what level of staff. In addition, it will ascertain the diagnosis and severity of illness of the clients treated. Finally, it will be possible to track patients through the total system to ascertain whether there is full utilization of the treatment continuum and services are appropriately accessible.

Summary

This policy statement represents, in many cases, a major departure from the way mental health services have been delivered in Los Angeles County in the past. However, we believe that it is appropriate to articulate and implement these policies at this time because our limited resources dictate a clear delineation of the Department's capabilities and accepted responsibilities. In addition, we feel that the new Department of Mental Health is now at a stage of maturity where it is capable of undertaking this redirection of our efforts in a serious and compassionate manner. We recognize that all echelons of the departmental and contract staff will be affected by these policies. In its 20 years, the public Mental Health system in Los Angeles County has had to struggle through many vicissitudes but it has always had dedicated

personnel who have tried to adapt to new technology, new systems, inadequate resources and high expectations in order to serve Los Angeles County residents as well as possible. We are confident that their commitment, dedication and professionalism will allow the implementation of this policy in a humane and expeditious manner so that the people of Los Angeles, regardless of age group and status, can be confident that they are receiving the most effective mental health care that current resources will allow.

JRE:jh

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