Contra Costa
Health Services

CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

1340 Arnold Drive, Suite 200
Martinez, California 94553
Ph (925) 957-5140
Fax (925) 957-5156
ccmentalhealth.org/mhc

Mental Health Commission

November 1, 2017 from 4:30pm-6:30pm
At: San Ramon Regional Medical Center
6001 Norris Canyon Road, San Ramon, CA
South Conference Room

I. Call to order/Introductions

II. Public Comment:
*Please note that all members of the public may comment on any item of public interest within the jurisdiction of the Mental Health Commission, in accordance with the Brown Act, if a member of the public addresses an item, not on the agenda, no response, discussion or action on the item may occur. Time will be provided for public comment on the items on the agenda, after commissioner's comments, as they occur during the meeting.

III. Commissioner Comments

IV. Chair Announcements –
- **The next Assisted Outpatient Treatment (AOT) meeting will be on Friday, January 19, 2018- from 10am to noon at: 50 Douglas Drive in Martinez, CA on the second floor.**

V. APPROVE Minutes from the October 4, 2016 Meeting

VI. RECEIVE updates regarding partnership programs throughout county school districts aiding in intervention among youth- Vern Wallace, Children/Adolescent Program Chief

VII. RECEIVE and DISCUSS Assisted Outpatient Treatment (AOT) quarterly meeting update- Warren Hayes, Program Manager

VIII. RECEIVE updates regarding the Mental Health Services Act budget planning process- Warren Hayes, Program Manager

IX. VOTE and ELECTION for the 2018 Chair, Vice Chair and three Executive Committee members

X. RECEIVE Commission liaison reports
1) **AOD Advisory Board – Sam Yoshioka**
2) **CPAW General Meeting – Douglas Dunn**
3) **Children's Committee – Barbara Serwin**
4) **Council on Housing Committee –TBD**

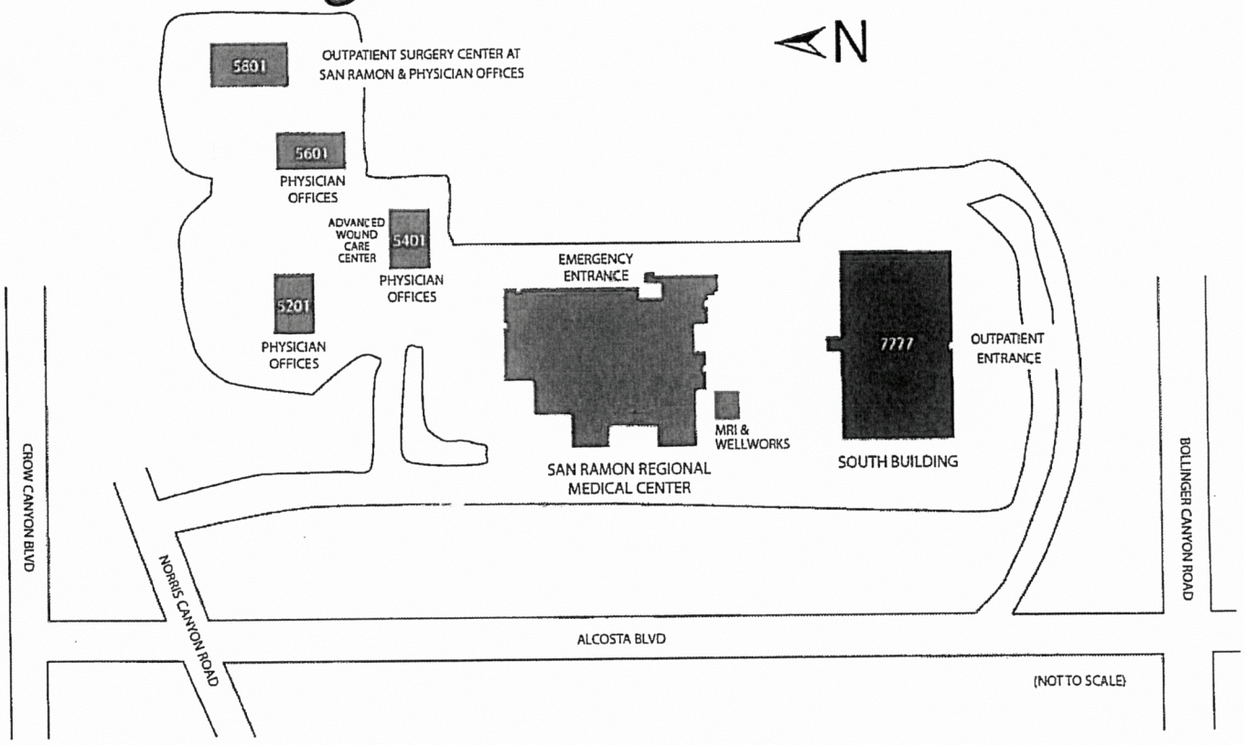
XI. Adjourn

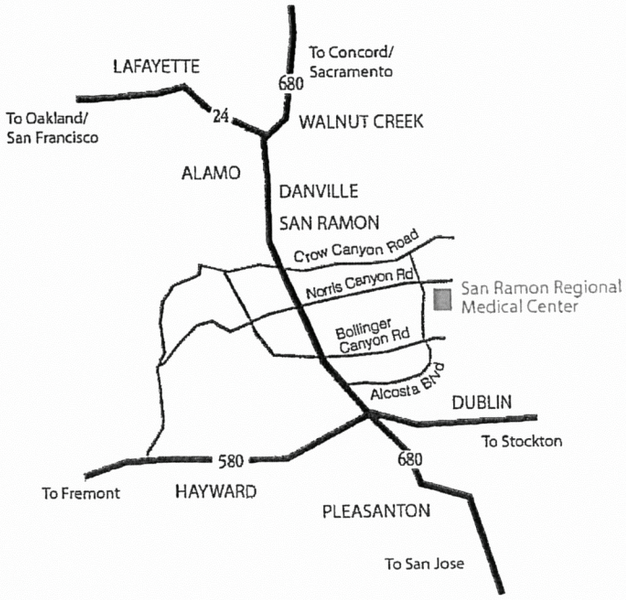
If special accommodations are required to attend any meeting, due to a disability, please contact the Executive Assistant of the Mental Health Commission, at: (925) 957-5140

Mental Health Commission

San Ramon Regional Medical Center Campus

meeting NOVEMBER 1, 2017





DIRECTIONS

From the North:
I-680 South
Exit: Crow Canyon Road, East (left)
Go to Alcosta Blvd., turn right
At Norris Canyon Road, turn left
and follow the signs up the hill

From the South:
I-680 North
Exit Bollinger Canyon Road, East (right)
Go to Alcosta Blvd., turn left
At Norris Canyon Road, turn right
and follow the signs up the hill

SAN RAMON
REGIONAL MEDICAL CENTER

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6001 Norris Canyon Road
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925.275.9200
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MENTAL HEALTH COMMISSION
MONTHLY MEETING MINUTES
Wednesday October 4, 2017 – First Draft
At: 550 Ellinwood Way, Pleasant Hill, CA

	Agenda Item / Discussion	Action / Follow-Up
I.	**Call to Order / Introductions** Commission Chair Duane Chapman called the meeting to order at 4:34pm Members Present: Chair- Duane Chapman, District I Vice Chair- Barbara Serwin, District II Supervisor Candace Andersen, District II Lauren Rettagliata, District II Diana MaKieve, District II Meghan Cullen, District V Sam Yoshioka, District IV Gina Swirsding, District I Douglas Dunn, District III Patrick Field, District III Commissioners Absent: Geri Stern, District I Michael Ward, District V Other Attendees: Jill Ray, Field Representative for District II, Supervisor Andersen's Office Vic Montoya, PES Program Chief April Langro, Director of RI International Linda Velarde, Public Jersey Neilson, Evaluator for BHS Admin Leslie May, applicant for MHC Erika Raulston, applicant for MHC Guita Bahramipour, AOD Advisory board Adam Down, BHS Admin Liza A. Molina-Huntley, EA for MHC	**EA-Transfer recording to computer**
II.	**Public Comments:** • Expressed difficulties regarding establishing and re-establishing Medi-Cal benefits for adult children with mental disabilities • Solution was offered to provide contact information for County staff member, with expertise in the area needed, Cassandra Kolto, Program Supervisor of the Financial Counselors to assist in the Medi-Cal applications. Her email is Cassandra.Kolto@hsd.cccounty.us and phone number (925) 372-4444 • NAMI in MOTION WALK 2017 will be at the Pleasant Hill park, on Saturday October 7, starting at 9am. • On October 14, "Out of the Darkness" Suicide Awareness walk will be at Cypress Grove park in Oakley, starting at 8:30am	
III.	**Commissioner Comments:** • New Commissioner interested in asking District III Supervisor, if a column can be started in a local paper regarding mental health and helping to stop the stigma. Will work with other District III members on the Commission. • Commission agreed to add "Committee updates," for Committee Chairs to	

report updates at the end of each full Commission meeting

- **Chair of the MHSA/Finance Committee** reported that the Committee has requested that the County's Finance Office provide updated financial budget documents, for the Behavioral/Mental Health Division at the Committee's November 16 meeting. The objective is to better understand the budget and expenditures, along with the different funding streams. Including monies spent on locked facilities and the location of these facilities. Including Realignment I/II money and expenditures.
- The following documents are available and can be requested to be sent via email, from the Executive Assistant: "**Mental Health Funding 101"** and "**California Revenue Behavioral Health update for 2016".** Both are great overviews of the funding system for Mental Health.
- **Ad Hoc Bylaws Committee updates**: the Chair of the committee went over the first four articles and made changes and will review the subsequent articles. The entire Mental Health Commission Bylaws document is in the process of being revised and updated. Invited everyone to attend the next meeting in October, at 3:30pm, at 1340 Arnold Drive, Suite 200, in Martinez at the Behavioral Health Administrative Offices. Appreciates everyone's input.
- **Quality of Care Committee Chair,** reported that the focus of the meeting was receiving updates from Victor Montoya regarding the current status of affairs at Psychiatric Emergency Services (PES), who has been invited to continue the discussion at the October 19 committee meeting and will continue to attend the meeting, for an ongoing discussion. The Chair encourages attendees to attend to keep informed.
- **Chair** request that a staff member from Financial Counseling and a staff member from Patient Accounting to help share how the process works for incoming consumers, at the County Medical Regional Center and at the County clinics.
- A new commissioner asked if PES is in the process of changing their intake area, currently it is very intimidating.
- **Justice Systems Committee Chair extended gratitude towards previous speaker and regular attendee, Dr. Dan Batiuchok, Manager of Juvenile Detention Mental Health Services.** His knowledge, dedication, time and caring of the detainee's, providing mental health services. The Chair is deeply concerned about youth that are in Juvenile Hall and are part of the foster care system; what services are available for foster care youth, after being released from Juvenile Hall? The Vice Chair of MHC and Chair of the Quality of Care Committee, also commented on Dr. Batiuchok and what an outstanding staff member he is and the work that he is doing is outstanding and would like him to come and present to the full Commission the progress that is being made at the mental health program, in Juvenile Hall and at the RANCH.
- Past Commissioner, Teresa Pasquini, is being honored in Washington D.C. as a "Champion for Change," for her work as an advocate.
- Commissioner, Douglas Dunn, is a mental health first aid trained instructor and, along with Behavioral Health Administration, is trying to get classes launched throughout the county. Asks Commissioners to assist in getting the word out to their communities, contact him or Adam Down, if interested in a class being held in their community. The class is targeted for the adult population, youth module will come later the county has committed to doing 30 trainings throughout the county. It is set up that there is a county and/or

	community trainer will facilitate all that is needed to conduct the class is the venue. The service is provided for free, an eight hour course or can be divided into 2 –four hour sessions, classes can be from 10 to 25 people, materials are $20 per book, and the trainer will come to the venue. Community trainers, working on their own, will charge $20 for the workbook only. If a county staff trainer, co-facilitates or conducts the training, the workbook is free all that is needed is to provide the location. The course is a basic, first aid mental health, eight hour course. • Chair asks that an announcement be made, in writing, with the full details and distributed.	
IV.	**Chair Announcements-** • **Announced that the next Mental Health Commission meeting will be in South County, on Wednesday, November 1, from 4:30 to 6:30pm in San Ramon.** **The location of the meeting will be at: San Ramon Regional Medical Center, 6001 Norris Canyon Road, in the South Conference room.** • **Chair was diagnosed with cancer, five years ago and was in remission. A few weeks ago was diagnosed with cancer again. Will continue to serve on the board.**	
V.	**MOTION to APPROVE minutes from September 16, 2017 meeting** **Sam moved to motion, Gina seconded the motion** • **Correct Adam's title-** • **VOTE: 10-0-0** • **YAYS: Supervisor Andersen, Duane, Gina, Doug, Sam, Diana, Barbara, Lauren, Meghan, Patrick,** • **NAYS: none ABSTAIN: none** • **ABSENT: Geri Stern and Michael Ward**	***Post final minutes to MH website at: http://cchealth.org/mentalhealth/mhc/agendas-minutes.php**
VI.	**RECEIVE and DISCUSS Assisted Outpatient Treatment (AOT) quarterly meeting update- TBD** • Commissioner that Chaired the previous AOT meeting, in September, informed that requested for staff members not to announce themselves as part of the forensic team, stating that there is nothing "forensic," regarding Laura's Law in the assisted outpatient treatment. It was a good meeting and speaker, Judge Austin oversees the judicial side of the AOT process, announced that not only those brought in under court order but those who voluntarily enroll will now receive be allowed to receive his services and visit with the judge. Judge Austin serves as facilitator to make sure that the person is committed to their treatment process. AOT meetings are quarterly and are co-Chaired with a Commissioner and Behavioral Health Services staff member. The next meeting has not been announced. Request another Commissioner to step up to co-Chair the next meeting. Douglas Dunn volunteered to Co-Chair the next quarterly meeting. Diana MaKieve offered to serve as an alternate, in case Mr. Dunn is unable to attend. • The MHSA Program Manager has committed to update the Commission regarding AOT and MHSA at the next meeting on November 1 in South County.	***AOT updates will be given at the 11/1/17 at the next MHC meeting in South County and announcement of the next AOT meeting**
VII.	**Receive UPDATES FROM THE Chair and Vice Chair regarding their collaboration with Behavioral Health Administration in preparation for the Family and Human Services future meetings** • Vice Chair stated that they are working, with Behavioral Health Administration (BHS) to respond to the Grand Jury Report, regarding	

	children's mental health care and responding to the White Paper. The Chair, Vice Chair and Commissioner Lauren Rettagliata has been working with the Director of Behavioral Health Services, Cynthia Belon, and the Program Chief of Children and Adolescents, Vern Wallace and Dr. White from Psych Emergency Services. The White Paper was intended to inspire the key issues that the county is struggling with, what possible approaches can be taken to work through the obstacles. A major part of the conversation has been BHS updating regarding new programs, newly hired staff and productivity analysis regarding psychiatrists. Define how many actual psychiatrists are needed to run the services efficiently and when new psychiatrists will be hired as full time staff. There are a number of workgroups that need to be attended to, before formulating responses. Their responsibility is to work on the White Paper, representing the different perspectives of Behavioral Health Services (BHS) and the Mental Health Commission (MHC), presenting both parties opinions. Both will present reports to the, Board of Supervisor's Chairing and Co-Chairing the meetings. • Ideally, the difference will be worked out between both parties and a single staff report would state the perspective of the division and the Commission's perspective along with a timeline in the plan for improvement- all would be included in the single report, instead of two conflicted reports. It is best to resolve all matters. • The Grand Jury process was explained as dealing with the Report stated, as a civil matter, no law suit, loss of revenue or criminal penalties will be applied in this matter. The panel of volunteers, serving the purpose to help government be more efficient. They investigate matters, brought to their attention, to make recommendations for improvements. The agency receives the recommendations, has a certain number of days to respond to the specific statements made by the Grand Jury. Behavioral Health provided responses and they were brought to Family and Human Services (FHS) to review the responses. The information is reviewed by the Chair and Vice Chair of the FHS, supplemental information was requested from the agency and will be brought to the Board of Supervisors to accept the report that will be forwarded onto the Grand Jury. The only power that the Grand Jury has is to raise the issue; there is no authority to provide a civil or criminal penalty. Another agency will pick up the matter, to take a deeper dive on the issues that were highlighted.	
VIII.	**RECEIVE announcement from the ad hoc Nominating Committee members, regarding the nominees for the 2018 Mental Health Commission Chair, vice Chair and Executive Committee** • The vote for nominees were done at the last month's meeting. There were four people that have the most votes for the Executive Committee: Douglas Dunn, Gina Swirsding, Michael Ward and Sam Yoshioka. For the Chair of the Mental Health Commission, the only nominee was Barbara Serwin. For the Vice Chair, the only nominee was for Duane Chapman. There are three seats available, out of five, since the Chair and Vice Chair serve on the Executive Committee. The other nominees for the Executive Committee are: Meghan Cullen, Diana MaKieve, Geri Stern and Lauren Rettagliata. All nominees will be placed on the ballot, for voting at the next month's meeting. Nominees need to accept their nomination. Meghan accepted her nomination, Diana accepted her	

	nomination, Gina accepted her nomination, Doug accepted his nomination, Lauren declined her nomination, and Sam accepted his nomination. Michael Ward and Geri Stern were not present to accept their nominations but their names will still be added to the voting ballot for next month's public election. The election will be done at the next Commission meeting. Each Commissioner will announce, publically, their vote. If there is a tie, the vote will be re-casted until the tie is broken.	
IX.	**REQUEST four to five volunteers from the Commission to complete the 2017 Data Notebook** • The 2016 Data Notebook has not been completed • The expectation for being on the ad hoc committee is to complete the assigned section and submit their portion by the end of February of 2018. The individual will answer the questions, in the Data Notebook, by acquiring input from BHS, programs and staff members to complete their responses and the individual will be responsible for their work in a document. They will submit their document, with the answers to the Executive Assistant to compile and submit the State Data Notebook to the agency indicated for public viewing and State data collection. It is the Commission's responsibility to complete the document and it is a great education process for the Commission. • **The 2017 Data Notebook focuses on older adult mental health care and the new "Whole Person Care" program. The ideal volunteer has a strong desire in the topic and enjoys doing research, documenting and writing.** • **The volunteers, from the Commission, to complete the 2017 Data Notebook are: Lauren Rettagliata, Gina Swirsding, Sam Yoshioka and Diana MaKieve** • A meeting will be facilitated by BHS, to meet with Older Adults Program Chief and other staff members, along with ad hoc members to start the dialogue and the informational retrieving process.	***the 2017 Data Notebook, ad hoc Committee will work with BHS staff to research the responses to the workbook. They will complete and submit to the EA, their section, by 2/28/18**
X.	**REQUEST Annual Committee Reports, including goals for 2018, from Committee Chairs, to be submitted at the next Commission meeting in November.** • **All Committee Chairs will submit their goals for their committee for 2018 on 11/1/17 in South County**	
XI.	**DISCUSS Commissioner's feedback regarding the 2017 Mental Health Commission retreat/training on Saturday September 16, 2017. What was learned and areas for improvement** • The areas discussed the most, during the training, were about building relationships with the Behavioral Health Services Director and with Board of Supervisor that appoints Commissioner. It is each Commissioner's responsibility to meet, regularly, with their District Supervisor. • Focus was made on "how to work together and get along to get the work done;" as a Commission and with the Director of Behavioral Health Services. This year, the topic was covered • The facilitator laid a good foundation on what the Commission should be working on and how. I was made, very clear, what the Commission's responsibilities are and that all need to work in a "partnership" and collaborate with one another. • It is important to continue the training on an annual basis • The Mental Health Commission's mandates are stated clearly and Commissioners need to keep them in mind, before taking action.	

XII. RECEIVE Commission Representative Reports **1) AOD Advisory Board- Sam Yoshioka** • Realignment funding was discussed, during the meeting. Two licensed Social Workers were in attendance and spoke about a Community Advisory Board (CAB) created to discuss AB109. • Although there are separate Realignment funding streams, I/II and AB109- a need has been identified, to be able to provide mental health care treatment, for individuals that are incarcerated. Funding is being utilized to support treatment efforts. **2) CPAW General meeting-Lauren Rettagliata** • Did not attend meeting • Doug informed that three community forums will be happening in different areas of the county. • 10/5/17 will be in West County, 10/25/17 will be in Martinez and December 7 will be in East County, from 2:30pm to 5:30pm at the Brentwood Community Center on 35 Oak Street. **3) Children's Committee- Barbara Serwin** • Did not attend meeting **4) Council on Homelessness- Lauren Rettagliata** • Did not attend meeting	**AOD is helping individuals with drug addiction disorder, focusing on recovery** **CPAW- 3 Community forums:** **1) 10/5/17 in West county** **2) 10/25/17 in Central** **3) 12/7 in East County**
XIII. Adjourn Meeting @5:58pm • **In memory of those who lost their lives in the Las Vegas massacre**	

Respectfully submitted,
Liza Molina-Huntley
Executive Assistant to the Mental Health Commission
CCHS Behavioral Health Administration

Plan for Maximum Enrollment of Persons Eligible for the AOT Program

Submitted By: Contra Costa Behavioral Health Services Division
Contra Costa Health, Housing and Homeless Services Division
Date: October 10, 2017
Point of Contact: Warren Hayes, MHSA Program Manager

Issue: After 19 months of a 36 month project period the Assisted Outpatient Treatment (AOT) Program is reported to have had 47 individuals deemed eligible and in receipt of assertive community treatment. The AOT Program has a caseload capacity of 75 persons.

Goal: Increase mental health treatment enrollment numbers to ensure all eligible persons receive this service, and thus facilitate maximum program and cost effectiveness. In particular, ensure that all AOT eligible seriously mentally ill persons who are homeless or at risk for being homeless receive this service.

Plan:

1. **By December 30** the Health, Housing and Homeless Division (H3) will develop and implement a protocol by which staff identify and refer potential candidates for the AOT Program to H3's licensed mental health clinical staff, who can then act as Qualified Requestors to Contra Costa Behavioral Health Services Division (CCBHS) investigative staff. This protocol, with accompanying training, addresses the current statutory requirement that only a Qualified Requestor can make a request for an investigation.
2. **Effective immediately** CCBHS staff will regularly coordinate with H3 staff to a) meet on a monthly basis to address confidentiality constraints the investigative process imposes on the ability to share client information, b) provide quarterly outreach and training opportunities to housing and homeless service providers, such as homeless shelters and the homeless continuum of care, in order to educate them on Qualified Requestor requirements, and c) facilitate monthly case coordination meetings between housing and homeless providers and Mental Health Systems (MHS), the AOT Program treatment provider, in order to ensure each homeless person made eligible for the AOT Program has simultaneous access to the best available behavioral health and housing services.
3. AOT Program staff (CCBHS and MHS) will proactively continue to engage Detention Mental Health staff, and **by December 1** a) provide an update to appropriate staff to be effective Qualified Requestors, b) streamline referral protocol, and c) improve communication of timing of contact visits and the release of current and potential AOT Program participants.

4. AOT Program staff to increase outreach and education efforts to the community, such as police and sheriff departments, hospitals (to include Contra Costa's Regional Medical Center and Psychiatric Emergency Services), Community Connect, probation, district attorney and public defender offices, and appropriate community based organizations **(ongoing)**.
5. **Effective immediately** CCBHS and MHS staff will implement procedures that facilitate court petitions sooner and more frequently in order to address persons who remain resistive to treatment participation. These procedures include, a) instituting a 30 day review after referral to MHS to assess the need for a petition, b) CCBHS keeping charts open after referral to MHS to consider appropriateness for a petition on an ongoing basis, and c) adding petition consideration to the weekly CCBHS/MHS managers' meeting agenda. This strategy will be monitored to determine impact on overall enrollment into the program.

Challenges: The above plan implements procedures to maximize coordination and collaboration among programs and services that can impact positively on the population likely to benefit from the AOT Program. However, challenges remain that will require constant attention in order to mitigate their impact on full enrollment.

1. *Housing Availability.* Homeless individuals who are participating in the AOT Program because of serious and persistent mental illness face the same challenges as any homeless person; namely, the lack of affordable housing. Persons who are likely to be eligible for the AOT Program face additional challenges, as by definition their condition is deteriorating and are likely to pose a danger to themselves or others. This does not make the ideal candidate for the limited supportive housing services that are currently available.
2. *Resistance to Treatment.* Persons who are resistant to treatment often are not able or desirous to engage with the service or housing options available to them. An example would be programs that require abstinence and sober living as a pre-requisite to participation. During the AOT Program project period Resource Development Associates, via external evaluation, has been tasked with determining the efficacy of mandating treatment through a civil court process.
3. *Confidentiality.* Until they are in receipt of a signed consent form program staff are legally prohibited from sharing any client information after a request for investigation is made and during the investigation period for AOT eligibility. During this period mutual sharing of information to enable service coordination becomes a challenge.

Contra Costa County Assisted Outpatient Treatment (AOT) Evaluation

MHS' ACTiOn Team 2017 Fidelity Assessment

Prepared by:

Resource Development Associates

August 21, 2017

Introduction

As an evidence-based psychiatric rehabilitation practice, Assertive Community Treatment (ACT) provides a comprehensive approach to service delivery to consumers with severe mental illness (SMI). ACT uses a multidisciplinary team, which typically includes a psychiatrist, a nurse, substance abuse and vocational specialists, and a peer counselor. ACT is characterized by 1) low client to staff ratios; 2) providing services in the community rather than in the office; 3) shared caseloads among team members; 4) 24-hour staff availability, 5) direct provision of all services by the team (rather than referring consumers to other agencies); and 6) time-unlimited services. When done to fidelity, the ACT model consistently shows positive outcomes for individuals with psychiatric disabilities. This flexible, client-driven comprehensive treatment has been shown to reduce risk and improve mental health outcomes.

The ACT service-delivery model relies on a multidisciplinary team of professionals who work closely together to serve consumers with the most challenging and persistent mental health needs. The ACT team works as a unit rather than having individual caseloads in order ensure that consumers receive the services and support necessary to live successfully in the community. The ACT team provides direct services to consumers *in vivo,* which means the ACT team must have a flexible service delivery model, providing consumers the services they need in the places and contexts they need them, as opposed to primarily in an office setting.

ACT is a nationally recognized evidence based practice with evidence dating back to the 1970s. According to outcomes from 25 randomized controlled trials, compared to usual community care, ACT more successfully engages clients into treatment, substantially reduces psychiatric hospital use, increases housing stability, and moderately improves symptoms and subjective quality of life.[1] Perhaps more importantly, research also suggests there are no negative outcomes associated with the ACT service delivery model. Recent research seeking to identify which client populations ACT is most effective for demonstrates that ACT is strongly effective and cost-effective for clients with a high frequency of psychiatric hospitalizations and less effective and not cost-effective for clients with a low frequency of psychiatric hospitalizations.

In Contra Costa County, Mental Health Systems (MHS) administers ACT. It is funded by the Mental Health Services Act (MHSA) Community Services and Supports as a Full Service Partnership program, and serves as the service component of Contra Costa's Assisted Outpatient Treatment (AOT) program. ACT offers adults with serious mental illness a full service partnership program that addresses mental health, housing needs, and community reintegration. Clients in the program have access to any team member, small caseloads for more individualized attention, nursing services and psychiatry, housing supports, and 24-hour availability.

[1] Bond, G.R., Drake, R.E., Mueser, K.T., and Latimer, E. (2001). Assertive Community Treatment for people with severe mental illness. *Disease Management and Health Outcomes, 9*(3), 141-159.

Fidelity Assessment Process

Contra Costa County, as part of a larger evaluation of the newly implemented AOT program, was interested in learning about ACT implementation. The intention of the fidelity assessment process is to measure the extent to which MHS' ACT team is in alignment with the ACT model and to identify opportunities to strengthen ACT/AOT services. For this component of the evaluation, RDA applied the ACT Fidelity Scale, developed at Dartmouth University[2] and codified in a SAMHSA toolkit.[3] This established assessment process sets forth a set of data collection activities and scoring process in order to determine a fidelity rating as well as qualifications of assessors.

Roberta Chambers, PsyD, and John Cervetto, MSW, conducted the ACT Fidelity Assessment. Both raters have extensive experience in community mental health programs as well as quality improvement and evaluation.

The fidelity assessment began with a series of project launch activities. This included:

1. Project launch call with CCBHS and MHS to introduce the fidelity assessment and desired outcomes, describe the assessment process, and confirm logistics for the assessment site visit.
2. Data request to CCBHS and MHS in advance of the site visit to obtain descriptive data about consumers enrolled in ACT since program inception.

The assessors conducted a full-day site visit at MHS' ACT team office in Concord, CA on July 13, 2017. During the site visit, the assessors engaged in the following activities:

- ACT team meeting observation
- Interviews with seven (7) ACT team members
- Review of available documentation
- Consumer focus group
- Family member focus group
- Debrief with the Team Leader

Concurrently, RDA obtained data from CCBHS and MHS and conducted descriptive analyses of the demographics and service utilization patterns of consumers enrolled in ACT.

Following the site visit and data analysis, the assessors each completed the fidelity rating scale independently and then met to seek consensus on each individual rating and to identify recommendations to strengthen MHS' ACT program fidelity rating. The results of that discussion and the fidelity assessment are presented in the proceeding Results and Discussion sections.

[2] http://www.dartmouth.edu/~implementation/page15/page4/files/dacts_protocol_1-16-03.pdf

[3] Substance Abuse and Mental Health Services Administration. *Assertive Community Treatment: Evaluating Your Program.* DHHS Pub. No. SMA-08-4344, Rockville, MD: Center for Mental Health Services Administration, U.S Department of Health and Human Services, 2008.

Fidelity Assessment Results

The ACT program was rated on the following three domains set forth in the ACT Fidelity Scale:

- Human Resources: Structure and Composition
- Organizational Boundaries
- Nature of Services

Each domain has specific criterion rated on a 5-point Likert scale with clearly defined descriptions for each rating. The following chart provides an overview of the domains, criterion, and ACTiOn Team's 2016 and 2017 program ratings. As shown in the table below, **the ACTiOn Team received an overall fidelity score of 4.42 indicating a high level of fidelity to the ACT Model.** The following section provides descriptions, justifications, and data sources for each criterion and rating.

Domain	Criterion	2016 Rating	2017 Rating
Human Resources: Structure and Composition	Small caseload	5	5
	Team approach	5	4
	Program meeting	5	5
	Practicing ACT leader	4	4
	Continuity of staffing	4	3
	Staff capacity	5	4
	Psychiatrist on team	5	5
	Nurse on team	5	5
	Substance abuse specialist on team	5	5
	Vocational specialist on team	5	5
	Program size	5	5
Organizational Boundaries	Explicit admission criteria	3	2
	Intake rate	5	5
	Full responsibility for treatment services	5	5
	Responsibility for crisis services	5	5
	Responsibility for hospital admissions	N/A	5
	Responsibility for hospital discharge planning	N/A	5
	Time-unlimited services	5	5
Nature of Services	In vivo services	3	3
	No drop-out policy	5	3
	Assertive engagement mechanisms	5	2
	Intensity of services	5	5
	Frequency of contact	4	4

Domain	Criterion	2016 Rating	2017 Rating
	Work with support system	5	5
	Individualized substance abuse treatment	5	5
	Co-occurring disorder treatment groups	5	5
	Co-occurring disorders model	5	5
	Role of consumers on treatment team	5	5
ACT Fidelity Score		**4.73**	**4.42**

Human Resources: Structure and Composition

Small caseload: 5

Small caseload refers to the consumer-to-provider ratio, which is 10:1 for ACT programs. MHS' ACTiOn Team received a rating of 5 for this criterion as they have 12.5 FTEs who provide direct services, as well as two administrative staff, for 32 active consumers and clearly exceeds the 10:1 ratio. This was assessed through personnel records and staff interviews.

Team Approach: 4

Team approach refers to the provider group functioning as a team rather than as individual team members with all ACT team members knowing and working with all consumers. MHS' ACTiOn Team received a rating of 4 for this criterion as 70% of consumers had face-to-face interactions with more than one team member in a two-week period. This was assessed through consumer records and further supported through the morning meeting observation, staff interviews, and consumer and family focus groups. *This is a slight decrease from the 2016 rating of 5 when 90% of consumers had face-to-face interactions with more than one team member in a two (2) week period.*

Program Meeting: 5

The program meeting item measures the frequency with which the ACTiOn team meets to plan and review services for each consumer. MHS' ACTiOn Team received a rating of 5 for this criterion as they team meets at least four times per week and reviews every consumer in each meeting. Assessors observed the program meeting during the site visit and observed the team discussion for every consumer as well as confirmed the frequency of program meeting through available documentation and staff interviews.

Practicing ACT Leader: 4

Practicing ACT leader refers to the supervisor of frontline staff providing direct service to consumers. Full fidelity requires that the supervisor provide direct service at least 50% of the time. MHS' ACTiOn Team received a rating of 4 because the Team Leader provides direct services about 30% of the time. These direct services include both formal and informal interactions and may or may not include formal progress notes.

Continuity of Staffing: 3

Continuity of staffing measures the program's level of staff retention. Full fidelity requires less than 20% turnover within a two-year period. During the evaluation period, seven staff discontinued employment with MHS' ACTiOn Team, which is a 47% turnover rate. This results in a rating of 3 based on the scoring rubric and was assessed through a review of personnel records and staff interviews. *This is a slight decrease from the 2016 rating of 4 where there was a 20% turnover rate.*

Staff Capacity: 4

Staff capacity refers to the ACT program operating at full staff capacity. According to personnel records, the MHS ACTiOn Team has operated at or above full staffing capacity 94% of the time. *This is a slight reduction from the 2016 rating of 4 where they operated at 100% staffing during the evaluation period.*

Psychiatrist on Team: 5

Fidelity to the ACT model requires 1.0 FTE psychiatrist per 100 consumers. Currently, MHS' ACTiOn Team provides 0.5 FTE psychiatrist for 32 active consumers, as reported by staff and personnel records. This results in a rating of 5. Once the program is at full capacity of 75 enrolled consumers, the team will require a .75 FTE psychiatrist to meet full fidelity to the ACT model.

Nurse on Team: 5

The ACT model requires a 1.0 FTE nurse per 100 consumers. Currently, MHS' ACTiOn Team employs two full-time nurses, including a registered nurse and licensed vocational nurse, as observed by personnel records and staff interviews. This exceeds the required ratio and results in a rating of 5.

Substance Abuse Specialist on Team: 5

The ACT model includes two staff with at least one year of training or clinical experience in substance abuse for 100 consumers. Currently, MHS' ACTiOn Team employs 2.0 FTE who meet criteria for a substance abuse specialist, as observed by personnel records and staff interviews. This exceeds the required ratio given 32 enrolled consumers and results in a rating of 5.

Vocational Specialist on Team: 5

The ACT model includes two staff with at least one year of training or experience in vocational rehabilitation and support for 100 consumers. Currently, MHS' ACTiOn Team employs a 1.0 FTE vocational rehabilitation specialist, as observed by personnel records and staff interviews. This exceeds the required ratio for 32 enrolled consumers and results in a rating of 5. When at full capacity of 75 consumers, the program will need to ensure that there are 1.5 FTE with the requisite experience in vocational rehabilitation.

Program Size: 5

Program size refers to the size of the staffing to provide necessary staffing diversity and coverage. MHS' ACTiOn Team exceeds the staffing ratio, as observed by personnel records and staff interview. This results in a rating of 5.

Organizational Boundaries

Explicit Admission Criteria: 2

Explicit admission criteria refers to 1) measureable and operationally defined criteria to determine referral eligibility, and 2) ability to make independent admission decisions based on explicitly defined criteria. MHS' ACTiOn Team, in partnership with CCBHS, has explicit admission criteria for enrollment into ACT. However, the responsibility for actively identifying and engaging potential ACT consumers lies primarily with CCBHS as a part of the larger Assisted Outpatient Treatment program, and MHS takes all consumers referred, regardless of independent review. For this reason, MHS' ACTiOn Team received a score of 2. *This represents a slight decrease from the 2016 rating of 3 because the MHS' ACTiOn Team has accepted consumers that they do not believe meet ACT criteria, including consumers who they believe have a primary substance use diagnosis as well as individuals with developmental disabilities. It is important to note that this does not suggest that MHS and CCBHS should change the process for ACT admission, but that there may be to strengthen collaboration between the two agencies during the admission process.*

Intake Rate: 5

Intake rate refers to the rate at which consumers are accepted into the program to maintain a stable service environment. In order to implement ACT with fidelity, a provider should have a monthly intake rate of six or lower. In the past six months, there have been no more than six consumers admitted in any given month resulting in a rating of 5.

Full Responsibility for Treatment Services: 5

Fidelity to the ACT model requires that ACT programs not only provide case management services but also provide psychiatric services, counseling/psychotherapy, housing support, substance abuse treatment, and employment and rehabilitative services. Currently, MHS' ACTiOn Team provides the full range of services, including psychiatric services, counseling/psychotherapy, housing support, substance abuse treatment, and employment and rehabilitative services. This was observed through program meeting observation, staff interview, a review of consumer personnel records, and input from a consumer focus group and results in a rating of 5.

Responsibility for Crisis Services: 5

The ACT model includes a 24-hour responsibility for covering psychiatric crises. MHS' ACTiOn Team provides 24-hour coverage through a rotating on-call system shared by all program staff, with the exception of administrative staff. The Team Leader provides back-up coverage and support. This was observed through program meeting observation and staff interviews as well as a review of personnel records and results in a rating of 5.

Responsibility for Hospital Admissions: 5

The ACT model includes the ACT program participating in decision-making for psychiatric hospitalization. Currently, MHS' ACTiOn Team collaborated with Psychiatric Emergency Services and Unit 4C on all decisions to hospitalize ACT consumers, resulting in a rating of 5.

Responsibility for Hospital Discharge Planning: 5

The ACT model includes the ACT program participating in hospital discharge planning. Currently, MHS' ACTiOn Team collaborated with Unit 4C and other inpatient units on all hospital discharge plans, resulting in a rating of 5.

Time-unlimited Services: 5

The ACT model is designed to be time-unlimited with the expectation that less than 5% of consumers graduate annually. MHS' ACTiOn Team graduated one consumer during the evaluation period, resulting in a rating of 5. This was determined through consumer records and staff interview. There were two consumers who moved out of the area during the evaluation period who were removed from this scoring criteria.

Nature of Services

In Vivo Services: 3

ACT services are designed to be provided in the community, rather than in an office environment. The community-based services item measures the number of MHS' ACTiOn Team contacts in a client's natural settings which refers to location where clients live, work, and interact with other people. For the period of evaluation, 59% of all encounters between the Action Team and Clients occurred in the community-based settings, which is a slight increase from last year's result of 53%. As this percentage falls between the range of 40% to 59%, the score for this measure is 3.

No Drop Out Policy: 3

This criterion refers to the retention rate of consumers in the ACT program. According to consumer records and staff report, nine consumers dropped out of the program, resulting in a 22% drop out rate and a rating of 3. Any consumer who moved out of the area was removed from the analysis for this criterion. *This represents a decrease from last year's rating of 5.*

Assertive Engagement Mechanisms: 2

As part of ensuring engagement, the ACT model includes using street outreach and legal mechanisms as indicated and available to the ACT team. While MHS' ACTiOn Team applies street outreach and other assertive engagement mechanisms, they do not appear to be using legal mechanisms specifically available to them, including the civil court petition for AOT, and instead appear to focus on building motivation for consumers to accept treatment voluntarily. This rating is informed by a small subset of consumers who initially accepted services on a voluntary basis but either 1) refused to participate once enrolled or 2) requested discharge despite continuing to meet criteria for ACT services. *It is important to note that the decision to use legal mechanisms is a collaborative effort between CCBHS and MHS, and the actual implementation of a legal mechanism, (i.e. AOT voluntary settlement agreement or court order) is shared between all AOT partners.*

Intensity of Services: 5

Intensity of services is defined by the face-to-face time service time MHS' ACTiOn Team staff spend with clients. Fidelity to the ACT model requires that consumers receive an average of two hours per week of face-to-face contact. During the evaluation period, ACT consumers received an average of 2.67 hours per week, resulting in a score of 5.

Frequency of Contact: 4

Fidelity to the ACT model requires that ACT consumers have an average of at least four face-to-face contacts per week. During the evaluation period, ACT consumers received an average of 3.15 contacts per week, resulting in a score of 4.

Work with Informal Support Systems: 5

The ACT model includes support and skill-building for the consumer's support network, including family, landlords, and employers. This criterion measures the extent to which MHS' ACTiOn Team provides support and skill-building for the client's informal support network as a way to further enhance the client's integration and functioning. According to staff, consumer, and family member discussions, MHS' ACTiOn Team is exceeding the expectation of 4 contacts per month with informal support systems, resulting in a rating of 5.

Individualized Substance Abuse Services: 5

The ACT model is based on an interdisciplinary team that provides all of the services a consumer may need to support their recovery and address their psychosocial needs, including individualized substance abuse treatment. MHS' ACTiOn Team provides individualized substance abuse services via the dual recovery specialist, family partner, and other clinical staff. This was observed through a review of personnel and consumer records, staff interview, and consumer focus groups and results in a rating of 5.

Co-Occurring Treatment Groups: 5

The ACT model is based on an interdisciplinary team that provides all of the services a consumer may need to support their recovery and address their psychosocial needs, including co-occurring disorder treatment groups. MHS' ACTiOn Team provides co-occurring disorder groups led by the dual recovery specialist, family partner, and other clinical staff. This was observed through a review of personnel and consumer records, staff interview, and consumer focus groups and results in a rating of 5.

Dual Disorders Model: 5

The ACT model is based on a non-confrontational, stage-wise treatment model that considers the interactions between mental illness and substance use and has gradual expectations of abstinence. The assessors were impressed with the implementation of motivational interviewing and stages of change principles throughout the program meeting and staff interviews and found that MHS' ACTiOn Team clearly meets and exceeds the treatment philosophy set forth in the ACT model. This results in a rating of 5.

Role of Consumers on Team: 5

The ACT model includes the integration of consumers as full-fledged ACT team members, usually in the provision of peer support and/or peer counseling. MHS' ACTiOn Team does include consumer membership as a part of the ACT team staffing. This was observed through a review of personnel records, team meeting observation, and staff interview and results in a rating of 5.

Other Feedback

ACT consumers and family members were generally appreciative of the ACT program and believed that participating in ACT had been beneficial. In addition to the strengths noted last year of **professional staff**, **partnership and responsivity**, and an **inclusive approach to services**, program strengths noted are:

- **Caring Staff:** Consumers and family members discussed feeling like MHS' ACTiOn Team staff are truly invested in consumers' lives and recovery processes. This was a clear differentiating factor for consumers and family when discussing if this program was different from other treatment experiences and how.
- **Outreach:** Both family members and consumers discussed how helpful the outreach process is with MHS' ACTiOn Team. Specifically, consumers and family discussed that staff come out to their homes or wherever they are and listen to their experiences and needs. Consumers described feeling cared about during the process and family discussed the relief they felt in knowing that someone was committed to help and willing to take the time to work with them and explain the process.
- **Consumer Outcomes:** It is notable that many consumers have made significant progress while in the program. Every consumer and family member interviewed was easily able to acknowledge an accomplishment as a result of participating. The assessors were also impressed with the consumers who have obtained and maintained housing, reduced crisis and hospitalization, and are either working or volunteering.

Discussion participants also provided suggestions for improving the program, including:

- **Meaningful Activities:** Consumers and family members shared that despite the frequent contact with members of MHS' ACTiOn Team, people still have a fair amount of free time. Both consumers and family members suggested that activity-based groups may be helpful to support consumers with their recovery goals. Suggestions included more game nights, art groups, barbeques, trips to the library or other community locales, and volunteering at the local animal shelter. This was a recommendation from last year, and appears to still be an area for continued growth.
- **Enrollment Process and Use of Petition:** Family members expressed concern at how long the enrollment process took to get their loved one through the process. Some family members discussed being denied services initially and then re-referring their family member after an additional crisis or jail experience in order to get them approved for the program. Additionally, family members expressed concern at the limited use of the petition and the length of time to decide to use a petition, if at all.

Discussion

Strengths

The assessors were impressed with a variety of elements of MHS' ACTiOn Team and observed that many of the program elements were present and met or exceeded fidelity measures. The program was robustly staffed with more team members than required with staff who are clearly committed to the success of the program and consumers. Staff demonstrated their familiarity with motivational interviewing and the recovery model in conversations with assessors and are working as a cohesive team. The program is structured to provide adequate staffing that can do "whatever it takes" to support consumers and meet them "wherever they're at," literally and figuratively. Team members appeared to work together throughout the day to ensure that all consumers receive individualized support to achieve their goals. Both consumers and family members expressed gratitude to MHS' ACTiOn Team and staff for the accomplishments that ACT consumers have achieved during program participation. Throughout the focus groups, assessors heard consumer and family member accounts of increasing stability and finding hope, as well as a number of tangible successes, including:

- Obtaining housing and income
- Reducing hospitalizations
- Feeling safe
- Improving and repairing family relationships
- Believing that recovery is possible

Opportunities

While the fidelity assessment revealed a high degree of alignment with the ACT model, there appear to be opportunities for improvement.

- **Staffing:** While MHS' ACTiOn Team is robustly staffed for the current caseload of 32, there would be gaps in some of the positions if the team were to grow to the contracted number of 75 consumers. Specifically, there would be a need to increase vocational rehabilitation and psychiatry time to ensure alignment with the model. Additionally, there has been a higher rate of turnover than expected. ACT being a new program in the County may influence this, and MHS may wish to explore how to increase staff retention for this program.
- **Civil Court Involvement:** The lowest scores from this assessment include the drop-out rate and use of legal mechanisms to compel participation. It may be useful for MHS and CCBHS to explore if there are ways for the program to maximize the use of the petition, specifically for 1) those who are determined by CCBHS to be eligible but are not willing to accept services after a period of outreach and engagement from MHS, and 2) those individuals who initially agree to ACT services on a voluntary basis and then fail to engage or request to be discharged despite continuing to meet eligibility criteria for AOT.
- **Capacity:** MHS' ACTiOn Team is contracted for up to 75 consumers and has served 43 consumers, of whom 32 are currently enrolled. MHS and CCBHS may wish to explore the barriers to

enrollment for consumers, including the use of the civil court petition and the length of time to become enrolled, as discussed previously, as well as consider how to best scale the program to ensure continued fidelity to the ACT model.

Conclusion

MHS' ACTiOn Team received an average fidelity rating of 4.42 and scored in the "high fidelity" range. The assessors were impressed with the staff, program implementation, and the success stories shared by staff, consumers, and their families. The assessors also recognized the opportunity to continue to improve the program, specifically around issues related to timely admission, the use of legal mechanisms to compel participation, and staff turnover. Additionally, the assessors recommend that CCBHS and MHS' ACTiOn Team explore what steps would be needed to enroll and serve 75 consumers while continuing the high degree of fidelity to the ACT model.

CONTRA COSTA COUNTY ASSISTED OUTPATIENT TREATMENT INTERIM EVALUATION

September 25, 2017

Resource Development Associates

Agenda

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- Introduction
- AOT Program Overview
- Pre-Enrollment
- AOT Enrollment
- Discussion

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Introduction

AOT Timeline

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February 5, 2015	February 1, 2016	February 1, 2016	February 5, 2016	March 4, 2016	June 30, 2017
• Contra Costa Board of Supervisors authorized Assisted Outpatient Treatment.	• CCBHS began accepting AOT referrals.	• CCBHS received its first referral and conducted its first investigation.	• MHS outreaches to the first eligible individual.	• MHS enrolls the first ACT consumer.	• In FY16/17, CCBHS received 177 referrals and MHS enrolled 43 ACT consumers

FY16/17 Interim Evaluation

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Purpose of FY16/17 Interim Evaluation:

- Provide information about AOT program implementation, ACT service provision, and preliminary findings.
- Support continuous quality improvement process to ensure the AOT program is meeting its intended goals.

- **Interim Evaluation Activities**
  - Secondary data analyses on AOT program services
  - Measure MHS' ACT fidelity
- **Interim Evaluation Period**
  - July 1, 2016 – June 30, 2017

Data and Limitations

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Data Provided

- CCBHS
  - Referral and investigation information
  - Service utilization data for all specialty mental health services provided or paid for by CCBHS
    - MHS contract payments
    - Estimated expenditures from CCBHS and justice partners
- MHS
  - Outreach and engagement contacts
  - Clinical assessments/outcomes
  - FSP assessments (PAF, KET, 3M)
  - ACT consumer and family focus groups (from ACT fidelity assessment)
- Sherriff's Office and Superior Court
  - Bookings, charges, and convictions

Limitations

- In 17 months, the program is still developing and modifying, which impacts data accessibility and quality.
- There are still relatively few consumers in ACT (43 who have spent an average of 243 days in ACT).
  - RDA standardized outcomes measures to rates per 180 days to account for variability in enrollment lengths and the vastly longer pre-enrollment data periods.

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AOT Program Overview

Pre- and AOT-Enrollment

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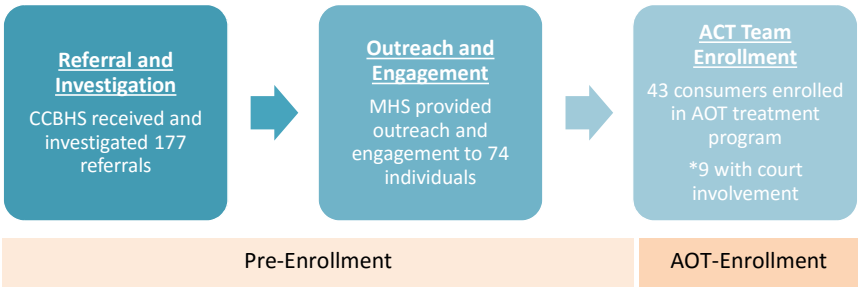

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Pre-Enrollment

RDA

Referrals and Investigations

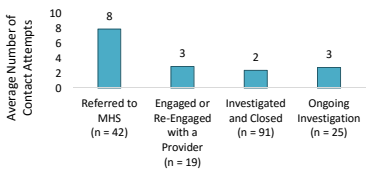
10

Referrals from mental health providers increased, while referrals from unqualified requestors decreased.

Requestor	% of Referrals February – June 2016 (n = 88)	% of Referrals July 2016 – June 2017 (n = 190)
Parent, spouse, adult sibling, or adult child	61% (n = 54)	63% (n = 120)
Treating or supervising mental health provider	11% (n = 10)	23% (n = 43)
Probation, parole, or peace officer	16% (n = 14)	11% (n = 20)
Adult who lives with individual	2% (n = 2)	1% (n = 2)
Director of hospital where individual is hospitalized	2% (n = 2)	0% (n = 0)
Director of institution where individual resides	0% (n = 0)	0% (n = 0)
Not a qualified requestor or "other"	7% (n = 6)	2% (n = 5)

Investigations resulting in referrals to MHS had many more contacts than other investigation outcomes.

Investigation Outcome	Number of Referred Consumers	% of Referred Consumers
Referred to MHS	42	24%
Engaged or Re-Engaged with a Provider	19	11%
Investigated and Closed	91	51%
Ongoing Investigation	25	14%



RDA

Outreach & Engagement

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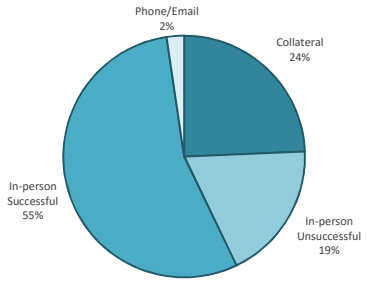
Nearly two-thirds (63%) of consumers that MHS conducted outreach and engagement with resulted in enrollment in ACT or another program.

Outreach and Engagement Outcome	Number of Consumers	% of Consumers
Enrolled in ACT Services in FY16/17	43	58%
Enrolled Voluntarily	*34*	--
Enrolled with Court Involvement	*9*	--
Engaged or Re-Engaged with Another Provider	4	5%
Closed by CCBHS	17	23%
Still Receiving Outreach and Engagement Services	10	14%

Over 80% of MHS' contacts were successful in reaching the consumer or collateral.



Referral to Enrollment Outcomes

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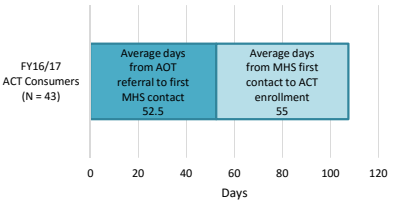
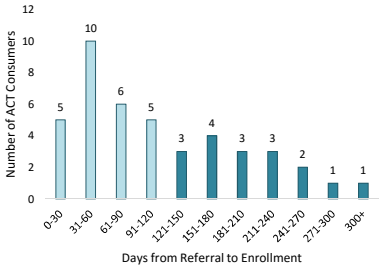
Average Length of Time from AOT Referral to ACT Enrollment



107 average days from referral to enrollment
4 – 281 days in range
79 median days

Length of Time from AOT Referral to ACT Enrollment



On average, for AOT treatment program consumers, it takes 107 days from the point of AOT referral to ACT enrollment.

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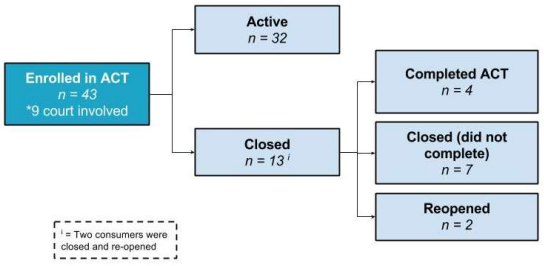
AOT Enrollment

AOT Treatment Program



Consumer Profile (N = 43)

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Category	ACT Consumers
Gender	
Male	53% (n = 23)
Female	47% (n = 20)
Race and Ethnicity	
Black or African American	23% (n = 10)
Hispanic	12% (n = 5)
White	56% (n = 24)
Other or Unknown	9% (n = 4)
Age at Enrollment	
18 – 25	25% (n = 11)
26 – 59	70% (n = 30)
60+	5% (n = 2)

- Diagnosis
  - **61% of consumers had primary diagnosis of psychotic disorder**, including schizophrenia and schizoaffective disorders
- Housing
  - **40% of consumers were homeless** at ACT enrollment
- Employment
  - **54% of consumers have supplemental security income**
  - **9% of consumers rely on family members or friends** for financial support

ACT Service Participation (N = 43)

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ACT Services

- Avg. length of enrollment: **243 days**
- Avg. number of service encounters: **6.5 face-to-face contacts per week**
- Avg. intensity of services: **6 hours of face-to-face contact per week**

ACT Treatment Adherence & Discharges

- The majority of consumers were adherent to ACT treatment (93%)
- 13 consumers were discharged from ACT during FY16/17
  - 2 re-enrolled at least once

ACT Fidelity Assessment

- Site visit on 7/13/17 that included:
  - Team meeting observation
  - Data and documentation review
  - Interviews with ACT team members (7)
  - Consumer Focus Group
  - Family Focus Group
- ACT Fidelity Score: **4.42**
  - High fidelity
- Other Feedback
  - MHS staff are caring and truly invested in consumers' lives and recovery processes
  - MHS conducts helpful outreach activities
  - Many consumers have made significant progress
- Participant Suggestions
  - Activity-based groups may be helpful
  - Consider using the AOT petition sooner

ACT Fidelity Assessment

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Strengths

- Robust staffing who are committed to consumers
- Familiarity with motivational interviewing and the recovery model
- Team members work together throughout the day to provide individualized support

Opportunities

- With MHS' current staffing, there would be gaps in some positions if the program had 75 consumers
- Explore if there are ways to maximize use of the petition
- Explore ways to scale the program to ensure continued fidelity to the ACT model

Psychiatric Hospitalizations and Crisis Episodes

19

On average, the **number of consumers** experiencing crisis episodes and psychiatric hospitalization, as well as **the frequency of crisis**, **decreased post-AOT** enrollment.

Crisis Episodes		
	Before ACT enrollment	**During ACT enrollment**
Number of Consumers (N = 43)	n = 40	n = 25
Number of Crisis Episodes	4.7 episodes per 180 days	3.1 episodes per 180 days
Average Length of Stay	1.8 days	1.1 days

Psychiatric Hospitalizations		
	Before ACT enrollment	**During ACT enrollment**
Number of Consumers (N = 43)	n = 29	n = 13
Number of Hospitalizations	1.3 hospitalizations per 180 days	1.1 hospitalizations per 180 days
Average Length of Stay	9.7 days	28.6 days

Criminal Justice Involvement

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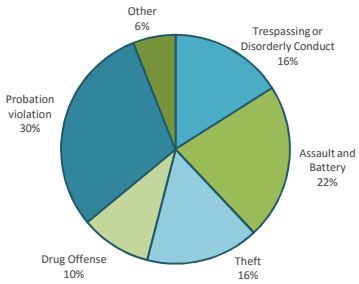
The **number of consumers experiencing criminal justice involvement decreased during ACT**, from 31 consumers pre-enrollment to 14 consumers during ACT enrollment.

Criminal Justice Involvement during ACT

Types of Bookings during ACT



Housing Status

21

The **majority of ACT consumers** (64%, n = 25) either **obtained or maintained** housing while in ACT.

Consumers' Housing Status before and during ACT (N = 39)

Consumers who obtained housing	Consumers who maintained housing	Consumers who were not stably housed
• 15% of consumers who were not housed before ACT obtained housing while enrolled	• 49% of consumers who were housed before ACT continued to maintain housing while enrolled	• 8% of consumers were housed before ACT but did not maintain housing during ACT • 28% of consumers were not housed before or during ACT enrollment

Social Functioning and Independent Living

22

ACT consumers experienced **slight increases in their self-sufficiency** while enrolled in ACT.

- Self-Sufficiency Matrix (18 domains, score out of 90 pts)
  - Intake average score: **41.15 pts** (n = 27)
  - 90-day reassessment average score: **48.14 pts** (n = 21)
  - 180-day reassessment average score: **45.87 pts** (n = 15)

Preliminary AOT Investments and Costs

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AOT Investments

- Expenses

County Department	FY 16/17 Cost
CCBHS (including FMH and MHS)	$1,960,001
County Counsel	$68,347
Public Defender's Office	$112,500
Superior Court	$3,378.00
Total County Costs	**$2,144,226**

- The cost of implementing AOT is $1,872,390, which includes actual expenses and revenue projections.

Cost Savings to Contra Costa County

- 3.5% savings in average annual cost per consumer
  - Reductions in costs incurred from criminal justice involvement and psychiatric hospitalizations

	Average Annual Cost per Consumer	
	12 Months before ACT	During ACT
All Behavioral Health Services	$82,788	$95,699
Bookings	$7,807	$2,450
Psychiatric Hospitalizations	*$69,715*	*$56,512*

RDA

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Discussion

RDA

AOT Care Team

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- **FMH and MHS work together** to identify, outreach, and engage eligible consumers in order to enroll them in ACT.
  - The Care Team meets consumers "where they're at" and strive to find and engage consumers and their support networks.
- AOT program has **engaged 46% of all AOT referrals** in the **appropriate level of mental health services.**
  - Care Team resolved 142 referrals in FY16/17
  - 66 referred consumers were connected to ACT or another service provider

Consumer Outcomes

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- The **majority of consumers experienced benefits** from participating in the AOT treatment program.
  - **Fewer consumers** experience **mental health crisis episodes, hospitalizations, and criminal justice involvement** while in the AOT treatment program.
  - **Increased social functioning and independent living skills** after 6 months in the AOT treatment program

Consumers that are Challenging to Locate

27

- Some referred individuals were **unable to locate**.
  - Referrals from confined settings (hospitals & jails) can be challenging to coordinate.
  - Referrals from the community present unique challenges because they may be homeless, unstably housed, or otherwise difficult to locate.

Considerations for AOT Team:

- Tracking mechanism on consumer face sheet to note an open or previous AOT referral.
- Training for PES, Inpatient Unit 4C, and jail mental health to screen for AOT and contact FMH/MHS when someone is ready for discharge.
- Education for qualified requestors to call FMH/MHS when individuals are at PES, hospital, or jail so they can go to the facility and make contact.

Using the Court Petition

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- Some individuals are **very difficult to engage in treatment**.
  - 18 non-AOT individuals continued to experience crisis, jail, and/or hospitalization post-referral.
  - 40% of ACT consumers enrolled more than 120 days post-referral.
  - 14% of ACT consumers requested and were discharged before completing ACT.
  - 30% of ACT consumers experienced increases in crisis, hospitalization, and criminal justice involvement.

Considerations for AOT Team:

- Using the AOT court petition in the following circumstances:
  - While the person is hospitalized/incarcerated;
  - If the person is unlikely to engage within 120 days;
  - If the person agrees to voluntarily participate but fails to engage or requests discharge prematurely; or
  - If the person agrees to participate but continues to experience crisis, hospitalization, and/or criminal justice involvement.

Next Steps

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- 2018 DHCS Report
  - Data collection and analysis: December 2017 – February 2018
  - DHCS Report (January 1, 2017 – December 31, 2017): March 2018
  - Presentation of DHCS report findings: April – May 2018
- ACT Fidelity Assessment
  - ACT Fidelity Assessment Activities: July 2018
  - ACT Fidelity Assessment Report: August 2018
- 2017-2018 Evaluation Report
  - Data collection and analysis: June – September 2018
  - AOT Evaluation Report (July 1, 2017 – June 30, 2018): October 2018
  - Presentations of Evaluation Report findings: November 2018

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Questions and Answers

Roberta Chambers, PsyD
rchambers@resourcedevelopment.net
510.984.1478

Contra Costa County Assisted Outpatient Treatment (AOT) Evaluation

Fiscal Year 2016/17 Evaluation Report

Prepared by:

Resource Development Associates

September 15, 2017

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Introduction

Background Information

In 2002, the California legislature passed Assembly Bill (AB) 1421 (also known as "Laura's Law"), which authorized the provision of Assisted Outpatient Treatment (AOT) in counties that adopt a resolution for its implementation. AOT is designed to interrupt the repetitive cycle of hospitalization, incarceration, and homelessness for people with serious mental illness who have been unable and/or unwilling to engage in voluntary services. AOT uses an expanded referral and outreach process that may include civil court involvement, whereby a judge may order participation in outpatient treatment. The California Welfare and Institutions Code[1] defines the target population, intended goals, and specific suite of services required to be available for AOT consumers in California (see Appendix I).

On February 3, 2015, the Contra Costa County Board of Supervisors adopted a resolution to authorize the implementation of AOT. Currently, Contra Costa County Behavioral Health Services (CCBHS) provides behavioral health services to AOT consumers through an Assertive Community Treatment (ACT) team operated by Mental Health Systems (MHS), a contracted provider organization. Contra Costa's AOT program represents a collaborative partnership between CCBHS, the Superior Court, County Counsel, the Public Defender, and MHS; community mental health stakeholders and advocates have remained involved in providing feedback and supporting the program to meet its intended objectives. The County's AOT program became operational on February 1, 2016 and accepted its first consumer in March 2016.

External Evaluation

Contra Costa County retained Resource Development Associates (RDA) to conduct an independent evaluation of its AOT program implementation. The purposes of this evaluation are to: 1) satisfy California Department of Healthcare Services (DHCS) reporting requirements; 2) provide information to the Board of Supervisors, AOT collaborative partners, and the community; and 3) inform the continuous quality improvement of the AOT program to support the County's intended objectives. Since the beginning of Contra Costa County's AOT program, RDA has produced three distinct evaluation reports, including two reports mandated by DHCS and another detailed report written specifically for CCBHS to better understand the implementation of its AOT program. All three prior evaluation reports documented: 1) program services, 2) consumers served, 3) fidelity to the ACT model, and 4) potential areas of improvement for the County's consideration. The reports were produced approximately six months apart, and document the implementation and continued progression of the AOT program since it began.

This report is the fourth report produced for the AOT program evaluation. The purpose of this report is to assist Contra Costa County with identifying the program's accomplishments and opportunities for

[1] Welfare and Institutions Code, Section 5346

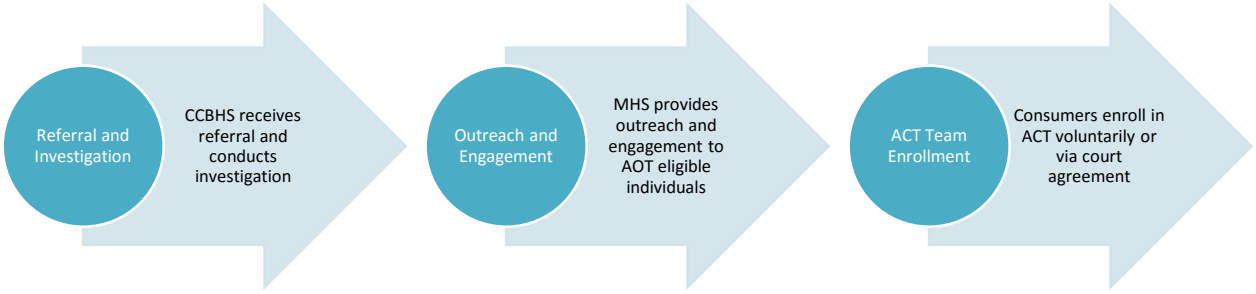
improvement. This report begins with a brief description of the AOT program's model followed by data analysis methodologies, evaluation findings, and discussion and recommendations.

In this report, RDA presents its evaluation findings in the same order that individuals experience the AOT program, from referral, investigation, outreach, and engagement that occur **pre-enrollment,** through the suite of services that individuals receive during **AOT enrollment**. One of the main purposes of AOT is to provide a mechanism to identify, engage, and retain individuals with the most serious mental health needs who are unable and/or unwilling to engage in services without additional supports and who may otherwise "fall through the cracks" in medically necessary mental health services. This report provides findings and recommendations that are intended to enable the County to: 1) build upon program strengths and resources, 2) identify and address emerging gaps and challenges, and 3) provide evidence-based services to consumers who require AOT to engage in medically necessary mental health services.

Contra Costa County's AOT Program Model

Contra Costa County has designed an AOT program model that responds to the needs of its communities and exceeds the requirements set forth in the legislation. The Contra Costa County AOT program includes a Care Team comprised of CCBHS Forensic Mental Health (FMH) and MHS staff. Figure 1 below depicts the Pre-Enrollment (Referral and Investigation; Outreach and Engagement) and AOT Enrollment (ACT outpatient treatment services) components of the AOT program.

Figure 1. Contra Costa County AOT Program Stages



AOT Process

The first stage of engagement with Contra Costa County's AOT program is through a telephone call referral whereby any "qualified requestor"[2] can make an AOT referral. Within five business days, a CCBHS mental health clinician connects with the requestor to gather additional information on the referral, and reaches out to the referred individual to begin determining if they meet AOT eligibility criteria (see Appendix I).

[2] Qualified requestors include: An adult who lives with the individual; Parent, spouse, adult sibling, or adult child of the individual; Director of an institution or facility where the individual resides; Director of the hospital where the person is hospitalized; Treating or supervising mental health provider; Probation, parole, or peace officer.

If the person initially appears to meet eligibility criteria, a CCBHS investigator from the FMH staff facilitates a face-to-face meeting with the consumer and/or family to gather information, attempts to engage the consumer, and develops an initial care plan. If the consumer continues to appear to meet eligibility criteria, FMH investigators share the consumer's information with the MHS team. MHS then conducts a period of outreach and engagement activities with the consumer to encourage their participation in ACT. If at any time the consumer accepts voluntary services and continues to meet eligibility criteria, they are immediately connected to and enrolled in MHS' ACT services.

However, if after a period of outreach and engagement, the consumer does not accept voluntary services and continues to meet eligibility criteria, the County mental health director or designee may choose to complete a declaration and request that County Counsel file a petition with the court. Utilizing a collaborative court model that combines judicial supervision with community mental health treatment and other support services, Contra Costa County then holds one to two court hearings to determine if criteria for AOT are met. At this time, the consumer has the option to enter into a voluntary settlement agreement with the court to participate in AOT. If the consumer chooses not to participate in AOT treatment services voluntarily, then he/she may be court ordered into AOT for a period of no longer than six months. After six months, if the judge deems that the person continues to meet AOT criteria, they may authorize an additional six-month period of mandated participation. At every stage of this process, CCBHS' FMH and MHS staff continue to offer the individual opportunities to engage voluntarily in services and may recommend a 72-hour hold if the consumer meets existing criteria.

AOT Process Outcomes

There are a variety of outcomes that may occur at each stage of the AOT process (see Figure 2). Given that the County's AOT program is relatively new, exploring the AOT process outcomes supports a shared understanding of program implementation, including implementation strengths, challenges, and gaps.

Figure 2. Process Outcomes during AOT Process

Referral and Investigation	Outreach and Engagement	ACT Team Enrollment
• Ineligible • Unavailable/ unable to locate • Referred to another service provider • Referred to MHS Outreach and Engagement	• Unavailable/ unable to locate • Accepts ACT services on a voluntary basis • Requires additional support to participate	• Accepts services through a voluntary settlement agreement • Accepts services with an AOT court order

AOT and ACT

It is important to note that Assertive Community Treatment (ACT) is not synonymous with Assisted Outpatient Treatment (AOT). AOT is a mechanism by which a county can use a civil court process to compel eligible individuals into a community mental health treatment program who are otherwise unwilling and/or unable to accept mental health treatment. An AOT petition can be initiated at any stage of the process, including:

- During the pre-enrollment phases of referral and investigation, or outreach and engagement;
- Following voluntary service acceptance, if the person fails to participate in services; and
- After the person participates in treatment, if they request discharge prematurely.

In Contra Costa County, the community mental health treatment component of AOT is ACT. Mental Health Services (MHS) is the contracted agency hired by CCBHS to implement an ACT team for County residents referred to AOT. It is not a requirement of AOT programs to offer ACT services to their consumers.

When the County first chose to implement AOT, the County also elected to implement a new level of outpatient mental health services by an ACT team. Additionally, it should be noted that the use of a civil court order process is in alignment with the ACT model. Fidelity to the ACT model includes the expectation that ACT programs apply assertive engagement mechanisms, including street outreach and available legal mechanisms, to compel participation. Legal mechanisms typically used in ACT programs include representative payees, terms and conditions of probation, outpatient commitment, and AOT court agreements such as voluntary settlement agreements and court orders.

Methodology

RDA employed a mixed-methods evaluation approach to assess implementation of the County's AOT program, as well as the extent to which individuals receiving AOT services during FY16/17 experienced decreases in hospitalization, incarceration, and homelessness, and improvements in psychosocial outcomes such as social functioning and independent living skills. This evaluation is intended to meet regulatory DHCS requirements and support continuous quality improvement (CQI) of the County's AOT program. We highlight the current evaluation period and who is included in the evaluation below:

- **Evaluation Period:** July 1, 2016 through June 30, 2017
- **Consumers Included:** Any consumer who was referred or received Care Team and/or ACT services during the evaluation period
- **Consumers Excluded:** Any consumer who was referred and closed before the evaluation period

The following sections describe the data measures, sources, and analytic techniques used to develop this report and evaluate Contra Costa County's AOT program.

Data Measures and Sources

This report is meant to provide a thorough evaluation of Contra Costa County's AOT program implementation and outcomes in order to identify programmatic strengths, as well as areas for continuous improvement. To this end, RDA assessed the outcomes and corresponding data measures highlighted in Table 1 below.

Table 1. AOT Outcomes and Corresponding Data Measures

Outcomes	Data Measures
Program Outcomes	
Homelessness	❖ Housing Status
Crisis Episodes	❖ Number and length of crisis episodes
Hospitalizations	❖ Number and length of hospitalizations
Criminal Justice Involvement	❖ Number and length of bookings into county jail ❖ Number of criminal cases for which charges were filed ❖ Number of criminal convictions
Program Costs	❖ Costs incurred and/or saved by the County
Treatment Outcomes	
Service Participation	❖ Intensity and frequency of services ❖ Treatment Adherence and Retention
Social Functioning & Independent Living	❖ Self Sufficiency Matrix scores

RDA collected data from several sources for this evaluation report. Table 2 below presents the County departments or agencies that provided data for this evaluation, as well as the data sources and elements captured by each data source. Appendix II provides additional information on each data source.

Table 2. Data Sources and Elements

County Department/Agency	Data Source	Data Element
Contra Costa County Behavioral Health Care Services	CCBHS AOT Request Log	❖ Individuals referred ❖ Qualified requestor information
	CCBHS AOT Investigation Tracking Log	❖ CCBHS investigation attempts
	Contra Costa County PSP Billing System	❖ Behavioral health service episodes and encounters, including hospitalizations and crisis episodes ❖ Consumer diagnoses and demographics
	CCBHS Financial Data	❖ Costs associated with implementing the AOT program, including ACT
Mental Health Systems	MHS Outreach and Engagement Log	❖ Outreach and engagement encounters
	FSP Forms in Access Database	❖ Residential status, including homelessness ❖ Employment ❖ Education ❖ Financial support
	MHS Outcomes Spreadsheet	❖ Social Functioning ❖ Independent Living ❖ Recovery
Contra Costa County Sheriff's Office	Sheriff's Office Jail Management System	❖ Booking and release dates ❖ Booking offense
Superior Court of California - Contra Costa County	Contra Costa Superior Court Case Management System	❖ Charges ❖ Convictions

Data Analysis

Throughout the data analysis process, RDA collaborated with CCBHS and MHS staff to vet analytic decisions and findings. RDA matched clients across the disparate data sources described above and used descriptive statistics (e.g., frequencies, mean, and median) for all analyses, including pre- and post-enrollment outcome analyses. In order to compare pre- and post-enrollment outcomes (i.e., hospitalizations, crisis episodes, and criminal justice involvement), RDA analyzed the rate (per 180 days) at which consumers experienced hospitalization, crisis, arrest, and criminal justice outcomes prior to and after enrolling in ACT. In future reports with larger sample sizes and longer consumer enrollment periods, both descriptive and inferential statistics will be used to explore AOT implementation and consumer outcomes.

Limitations and Considerations

As is the case with all "real-world" evaluations, there are important limitations to consider. One limitation of this evaluation is that only 43 consumers participated in the AOT treatment program during FY16/17. Because relatively few individuals were enrolled during this period, the proportion of individuals who experienced crisis, hospitalization, and criminal justice involvement, as well as the average rates of occurrence, shift somewhat drastically based on the experiences of relatively few individuals.

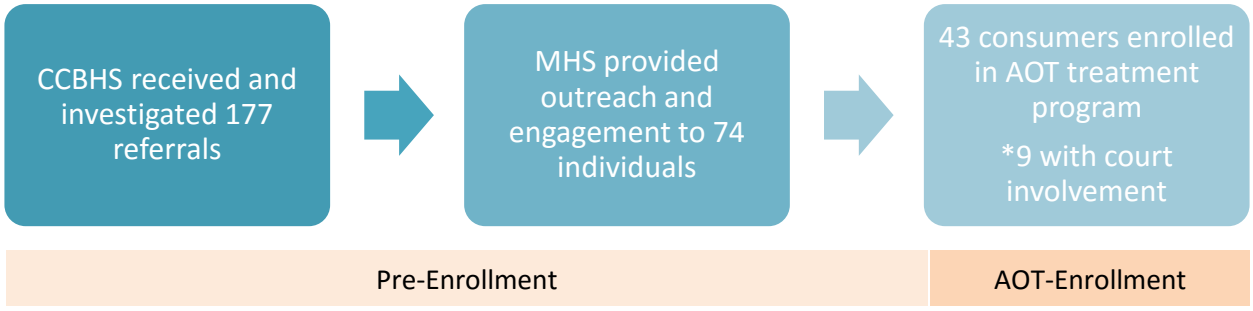
It is also important to note that there is more data available for the longer pre-enrollment time periods compared to the shorter post-enrollment time periods. Therefore, AOT consumers had greater opportunities to experience negative outcomes prior to program enrollment than after program enrollment. To account for differences in the pre- and post-time periods, RDA standardized outcomes measures to rates per 180 days. Nevertheless, because consumers have spent much less time in AOT than in the pre-enrollment period, there is less opportunity for them to experience outcomes such as hospitalization, arrest, and/or incarceration during their AOT participation period. As a result, these outcomes may be underestimated if a large number of consumers experienced zero negative outcomes during shorter periods while they were enrolled in AOT. On the other hand, if consumers experienced a number of negative outcomes for lengthy periods during their AOT enrollment period, these estimations may be overestimated.

Despite these limitations, this evaluation will help Contra Costa County to identify the successes and challenges of its AOT implementation, as well as to highlight the outcomes of consumers who participated in the County's AOT treatment program in FY16/17. These findings resulted in recommendations for the County to consider as they strive to continuously improve implementation and outcomes for all individuals referred to the County's AOT program.

Findings

This evaluation includes findings for all consumers who were referred to AOT or received Care Team and/or ACT services from July 1, 2016 through June 30, 2017. During this time, CCBHS received 190 referrals to AOT for 177 unique individuals. Of these 177 individuals, 76% (n = 135) were not referred to MHS for outreach and engagement. The remaining 42 consumers were referred to MHS for outreach and engagement, and 15 enrolled in the County's AOT treatment program. In addition, 32 consumers who were referred to AOT in FY15/16 received MHS services during FY16/17 and are included in this report.

Figure 3. Consumers Referred to AOT and/or Receiving MHS Services during FY16/17

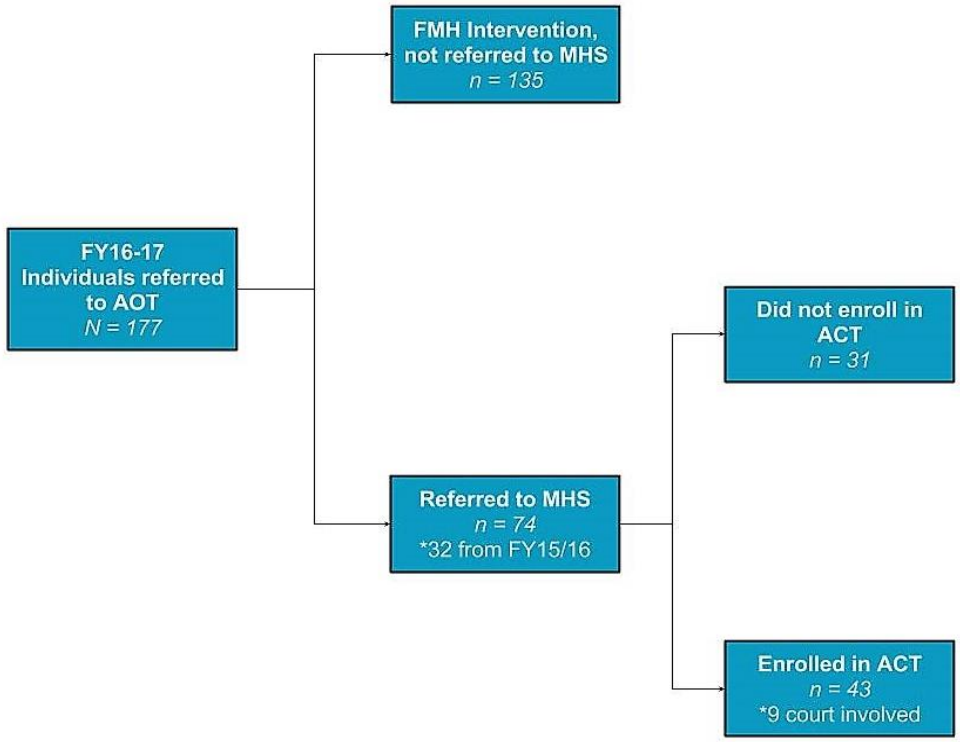


Findings are divided into two sections: "Pre-Enrollment" and "AOT Enrollment." CCBHS staff and/or MHS' ACTiOn team provide investigation, outreach, and engagement services for all individuals who are referred to AOT in order to connect them to the AOT treatment program, if eligible, or some other mental health treatment, if they are not. We explore the outcomes of this process in the "Pre-Enrollment" section, and report on outcomes for all individuals who met AOT eligibility requirements and participated in the County's AOT treatment program during FY16/17 in the "AOT Enrollment" section.

Pre-Enrollment

Figure 4 below demonstrates that 177 individuals were referred to AOT in FY16/17. Among those individuals, 135 were not referred to MHS for outreach and engagement. The remaining 42 consumers were referred to MHS for outreach and engagement, and an additional 32 consumers were referred to AOT in FY15/16 and received MHS outreach and engagement and/or ACT services during FY16/17.

Figure 4. FY16/17 AOT Program



First, we provide an overview of referrals made to AOT during FY16/17, including a profile of who made these referrals, and referral dispositions. Next, we detail the investigation, outreach, and engagement processes — led by CCBHS FMH and MHS' ACTiOn team respectively — and assess outcomes such as hospitalization and/or criminal justice involvement experienced by consumers prior to enrolling in the County's AOT treatment program.

Referral to AOT

CCBHS received 190 AOT referrals during FY16/17 for 177 unique individuals. Thirteen consumers were referred to AOT twice during this fiscal year; these consumers 1) did not initially meet AOT eligibility criteria, 2) were initially connected or reconnected with other services, or 3) were still under investigation at the conclusion of the evaluation period.

The majority of AOT referrals (63%) continue to come from consumers' family members.

Since program inception, the majority of referrals to AOT have been made by consumers' family members. This trend continued in FY16/17, with 63% of referrals coming from family members (see Table 3). Referrals to AOT were also made by treating or supervising mental health providers (23%, n = 43) and members of law enforcement agencies (11%, n = 20).

Table 3. Summary of Qualified Requestors

Requestor	% of Referrals February – June 2016 (n = 88)	% of Referrals July 2016 – June 2017 (n = 190)
Parent, spouse, adult sibling, or adult child	61% (n = 54)	63% (n = 120)
Treating or supervising mental health provider	11% (n = 10)	23% (n = 43)
Probation, parole, or peace officer	16% (n = 14)	11% (n = 20)
Adult who lives with individual	2% (n = 2)	1% (n = 2)
Director of hospital where individual is hospitalized	2% (n = 2)	0% (n = 0)
Director of institution where individual resides	0% (n = 0)	0% (n = 0)
Not a qualified requestor or "other"	7% (n = 6)	2% (n = 5)

It is also worth noting that only 2% of referrals were from unqualified requestors during FY16/17, compared to 7% of referrals from unqualified requestors during the program's first five months. It appears that over time, Contra Costa County residents have developed a greater understanding of the AOT treatment program, including who meets the requirements of a qualified requestor.

Care Team

Contra Costa County's Care Team consists of CCBHS' FMH and MHS staff. CCBHS FMH receives all AOT referrals and conducts an investigation for each individual referred in order to determine AOT eligibility (see Appendix I for AOT eligibility requirements). CCBHS FMH refers AOT eligible consumers to MHS staff, who conduct outreach and engagement to enroll them in ACT services. The following section discusses the investigations conducted by CCBHS FMH, and outreach and engagement activities conducted by MHS.

Investigation

After CCBHS receives an AOT referral, the FMH team conducts an investigation to determine if the individual meets the eligibility criteria for the AOT program. In addition to consulting prior hospitalization and mental health treatment records for the individual, and gathering information from the qualified requestor, the FMH investigation team also attempts to make contact with the referred individual in the field.

Approximately one-fourth of consumers referred to CCBHS FMH (24%) were eligible for AOT and subsequently referred to MHS; approximately half (51%) of consumers referred were ineligible for AOT.

During FY16/17, CCBHS FMH investigated 177 unique consumers.[3] Approximately one-fourth (24%, n=42) of consumers were determined to be eligible for AOT and referred to MHS for outreach and engagement, while 11% (n = 19) of consumers engaged or re-engaged with another provider, and 14% (n = 25) were still being investigated by CCBHS FMH at the conclusion of FY16/17 (see Table 4 below).

[3] An additional nine consumers were still under investigation from the previous fiscal year. All of these nine consumers were ineligible.

Table 4. Outcome of CCBHS Investigations (N = 177)

Investigation Outcome	Number of Referred Consumers	% of Referred Consumers
Referred to MHS	42	24%
Engaged or Re-Engaged with a Provider	19	11%
Investigated and Closed	91	51%
Ongoing Investigation	25	14%

Approximately one-half (51%) of individuals referred to AOT were determined to be ineligible. Individuals were ineligible for the following reasons:

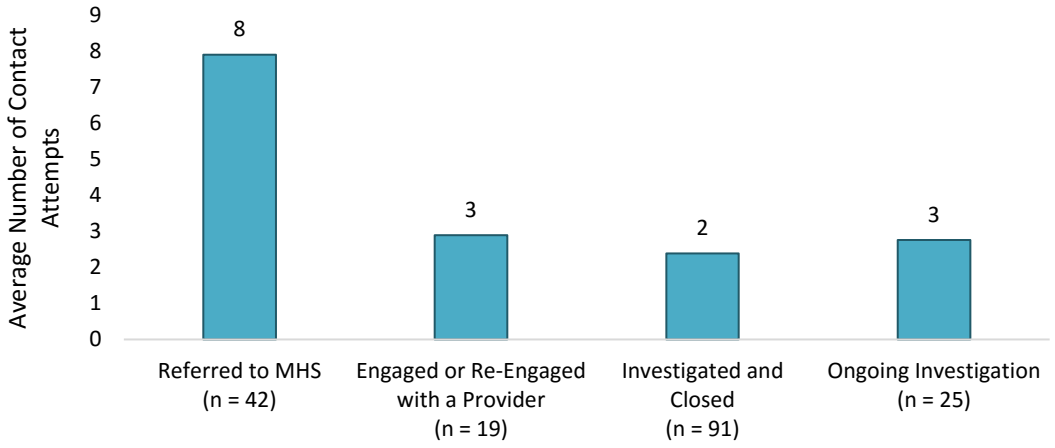
- They did not meet the AOT eligibility criteria;
- They were unable to be assessed for eligibility (i.e., unable to locate, extended incarceration, or extended hospitalization);
- The qualified requestor withdrew the referral; or
- The qualified requestor could not be reached.

CCBHS FMH worked to connect individuals who were ineligible for AOT to the appropriate level of mental health treatment, and also provided resources and education for ineligible consumers' family members.

The County's investigation team was persistent in their efforts to locate consumers, determine consumers' eligibility for AOT, and connect eligible consumers to MHS.

On average, CCBHS FMH's investigation team made four contact attempts to each individual referred to AOT. As shown in Figure 5, the investigation team made the most contact attempts, on average, to those consumers who were eventually referred to MHS for outreach and engagement.

Figure 5. Average Investigation Contact Attempts per Consumer (N = 177)



The investigation team worked to meet consumers "where they're at," as evidenced by the variety of locations where investigation contacts occurred. While approximately one-quarter (26%, n = 199) of investigation contact attempts occurred in a County office, another quarter (24%, n = 184) of investigation

attempts took place in the field. Teams also met consumers at their place of residence, as well at inpatient, healthcare, and correctional facilities.

Outreach and Engagement

If the CCBHS FMH team determines that a consumer is eligible for AOT, the consumer is connected with MHS. The MHS team then conducts outreach and engagement activities with those individuals and their family to engage the individual in AOT services. As per the County's AOT program design, MHS is charged with providing opportunities for the consumer to participate on a voluntary basis. If, after a period of outreach and engagement, the person remains unable and/or unwilling to voluntary enroll in ACT and continues to meet AOT eligibility criteria, MHS may refer the individual back to FMH to file a petition to compel court ordered participation.

MHS conducted comprehensive outreach in order to engage consumers — and their support networks — and enroll them in the County's ACT program.

MHS conducted outreach and engagement with 74 consumers, 43 of whom enrolled in ACT.[4] The remaining consumers either engaged/re-engaged with another provider, were closed by CCBHS (for reasons described above), or were still receiving outreach and engagement services as of June 30, 2017 (see Table 5).

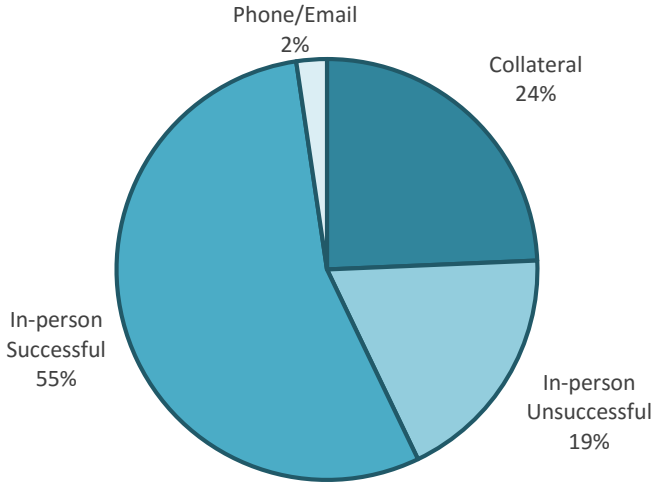
Table 5. MHS Outreach and Engagement Outcomes (N = 74)

Outreach and Engagement Outcome	Number of Consumers	% of Consumers
Enrolled in ACT Services in FY16/17	43	58%
Enrolled Voluntarily	*34*	--
Enrolled with Court Involvement	*9*	--
Engaged or Re-Engaged with Another Provider	4	5%
Closed by CCBHS	17	23%
Still Receiving Outreach and Engagement Services	10	14%

MHS provided outreach and engagement services to consumers as well as consumers' support networks. Approximately three-fourths (75%) of all outreach and engagement attempts were with consumers, while one-fourth (24%) of outreach and engagement attempts were with consumers' support networks. Overall, the majority of successful contacts with consumers were in person, and approximately one in five outreach and engagement efforts were unsuccessful.

[4] 17 ACT consumers who received outreach and engagement services in FY15/16 are included in this discussion in order to capture the total efforts of outreach and engagement required to enroll all FY16/17 ACT consumers.

Figure 6. Type of Outreach and Engagement Contacts (N = 652)



MHS relies on a diverse multidisciplinary team to conduct outreach and engagement. For consumers receiving services in FY16/17, the majority of outreach attempts were either from a peer partner (45%) or the clinical team leader (26%). As with the County's investigation team, MHS was persistent in their efforts to meet consumers "where they're at." Most contact attempts occurred in the community (25%), the hospital (21%), consumers' homes (15%), or at MHS' office (15%).

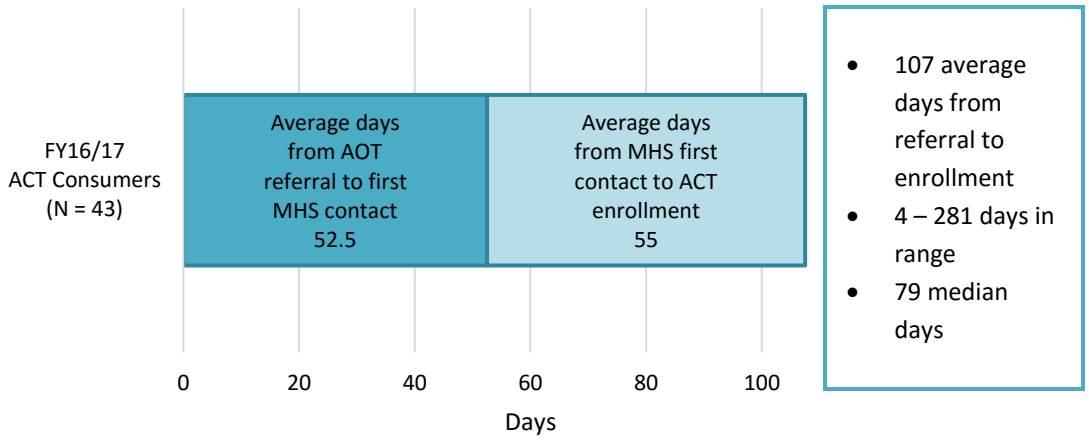
Referral to Enrollment Outcomes

This section explores the period from initial referral through AOT enrollment. This includes referral and investigation efforts by CCBHS FMH as well as outreach and engagement efforts by MHS.

The average length of time from referral to enrollment is 107 days.

Contra Costa County designed an AOT program model that sought to engage and enroll consumers in ACT within 120 days of referral. On average, it took the Care Team approximately 107 days to collectively conduct investigation, outreach and engagement, and enrollment of consumers in AOT. Specifically, it took an average of 52.5 days from the point of AOT referral to MHS' first contact, and 55 days from the point of MHS' first contact to enrollment in ACT (Figure 7).

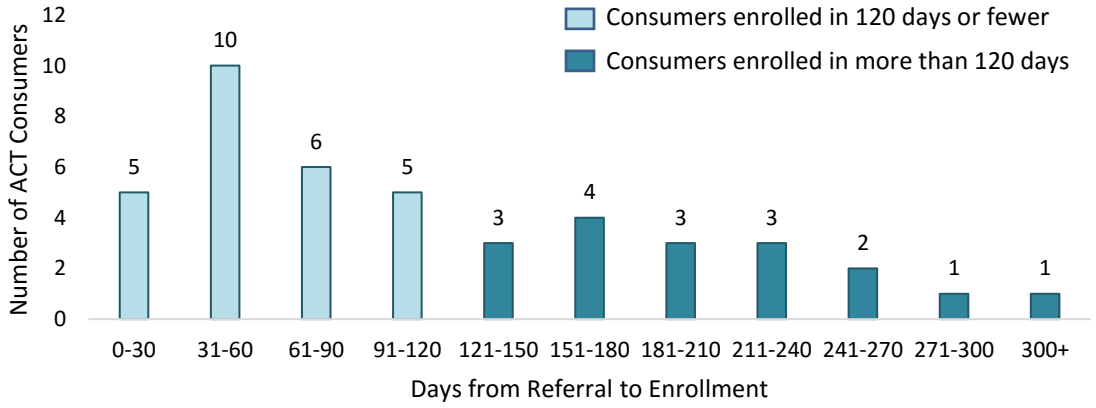
Figure 7. Average Length of Time from AOT Referral to ACT Enrollment



Some individuals experienced referral to enrollment periods longer than 120 days.

Contra Costa County's AOT program model has an expected maximum period of four months from the point of referral to enrollment in AOT treatment services. Although the average length of time from referral to enrollment aligned with the County's program design, 17 consumers (40%) had investigation and outreach periods lasting longer than 120 days (Figure 8). Data suggest that these individuals were difficult to locate, and that the Care Team invested additional time to attempt to locate, assess, and engage these individuals.

Figure 8. Length of Time from AOT Referral to ACT Enrollment

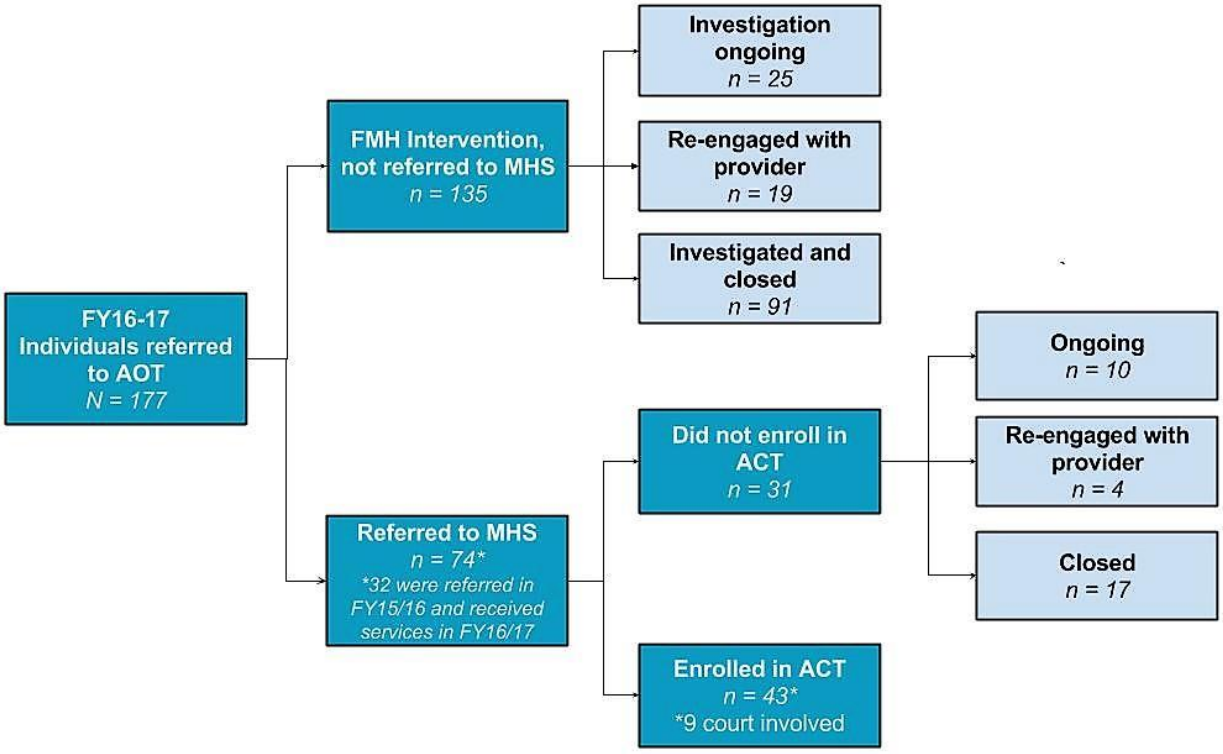


Among individuals whose pre-enrollment period lasted longer than 120 days, approximately 63% (n = 10) experienced a hospitalization and/or criminal justice involvement during this referral to enrollment period.

Summary

Figure 9 summarizes the outcomes of all referrals to AOT following the Care Team's investigation, outreach, and engagement efforts. At the end of FY16/17, 110 consumers were closed, while 25 were still under investigation. Of those investigated and connected to MHS (n = 74), 43 enrolled in ACT. Among those not enrolled, 17 were closed by the County, 4 engaged or re-engaged with another provider, and 10 were still receiving outreach and engagement services.

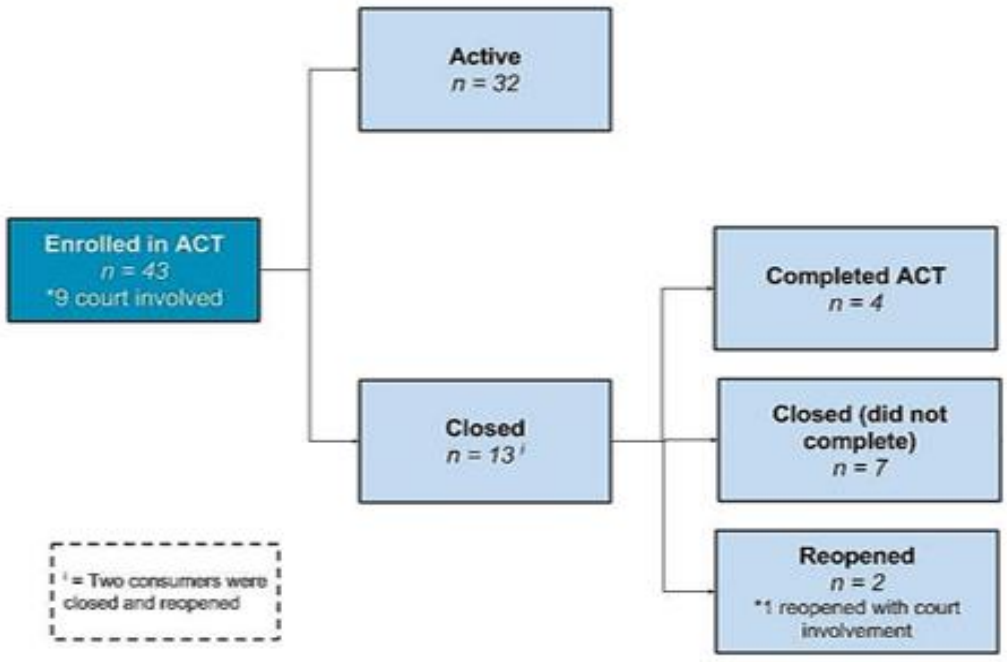
Figure 9. Referred Consumers



AOT Enrollment

Figure 10 below demonstrates that the MHS ACTiOn team enrolled and/or served 43 consumers in FY16/17. Thirty-two (32) consumers were active at the conclusion of FY16/17, while 13 consumers discharged from the AOT treatment program at some point during the fiscal year. Of the 13 who discharged from the program, two re-enrolled in ACT during this fiscal year, four completed the program, and seven left prematurely. This section describes outcomes for the 43 consumers who received ACT services during FY16/17.

Figure 10. FY16/17 AOT Treatment Program Participants



In this section, we first provide a consumer profile of AOT treatment program participants, including their demographic characteristics and diagnoses. Then, we focus on the intensity and frequency of service participation among consumers, followed by a discussion of consumer outcomes, including the extent to which participants experienced crisis episodes, psychiatric hospitalizations, and criminal justice involvement. Finally, we highlight program costs and costs savings associated with reduced numbers of hospitalizations and criminal justice involvement, as well as revenue generated through federal reimbursement.

ACT Consumer Profile

The following section describes consumers' demographic characteristics, as well as their diagnoses, employment status, educational attainment, and sources of financial support when they enrolled in ACT.

Demographics

The AOT treatment program is enrolling the target population, although 25% of those enrolled are younger than expected.

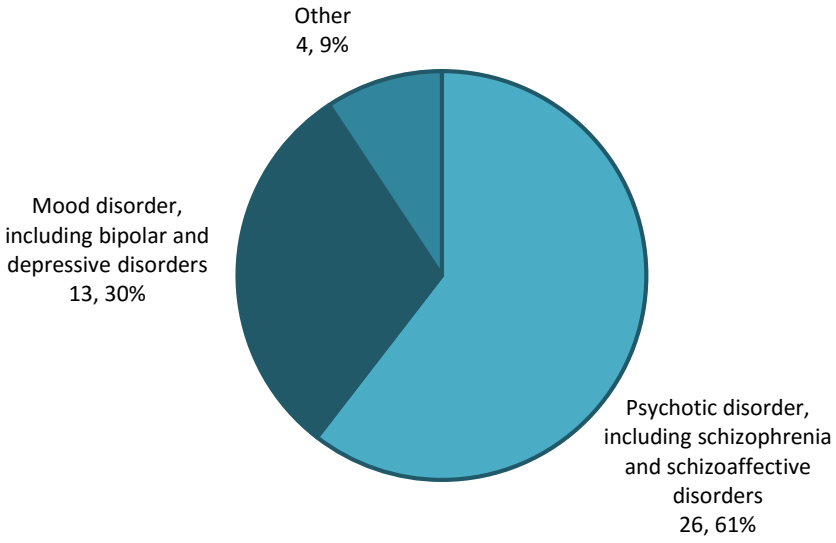
As shown in Table 6, ACT consumers were primarily male (53%, n = 23), white (56%, n = 24), and between the ages of 26 and 59 (70%, n = 30). Approximately 25% of ACT consumers are transitional age youth (TAY) between the ages of 18 and 25. While this is not completely unexpected given that the majority of major mental health disorders have an onset during the TAY period, TAY may have service needs that differ from the adult population.

Table 6. ACT Consumer Demographics (N = 43)

Category	ACT Consumers
Gender	
Male	53% (n = 23)
Female	47% (n = 20)
Race and Ethnicity	
Black or African American	23% (n = 10)
Hispanic	12% (n = 5)
White	56% (n = 24)
Other or Unknown	9% (n = 4)
Age at Enrollment	
18 – 25	25% (n = 11)
26 – 59	70% (n = 30)
60+	5% (n = 2)

Sixty-one percent (61%) of ACT consumers (n = 26) had a primary diagnosis of a psychotic disorder (see Figure 11) and 79% (n = 34) had a co-occurring substance use disorder at the time of enrollment.

Figure 11. Primary Diagnosis at Referral (N = 43)



Housing, Education, Employment, and Financial Support

At the time of enrollment, approximately 42% (n = 18) of consumers were housed (e.g., living with family or in a supervised placement) and 9% (n = 4) were living in a residential program. Approximately 40% (n = 17) of consumers were homeless or living in a shelter at enrollment; four consumers' housing status was unknown.

Table 7. Housing Status at ACT Enrollment (N = 43)

Residence	Living Arrangement at Enrollment
Housed	42% (n = 18)
Residential Program	9% (n = 4)
Shelter/Homeless	40% (n = 17)
Unknown or Not Reported	9% (n = 4)

ACT consumers also reported on their highest level of educational attainment, and whether they were in school at the time of enrollment. Most consumers had some college education or technical training (35%, n = 15) or higher levels of education (19%, n = 8), and the majority were not in school (72%, n = 31; see Figure 12 and Figure 13). All consumers with a high school diploma/GED or less were not in school at the time of ACT enrollment, or their school status was unknown. Just over half of consumers (53%) included education as a recovery goal.

Figure 12. Educational Attainment (N = 43)

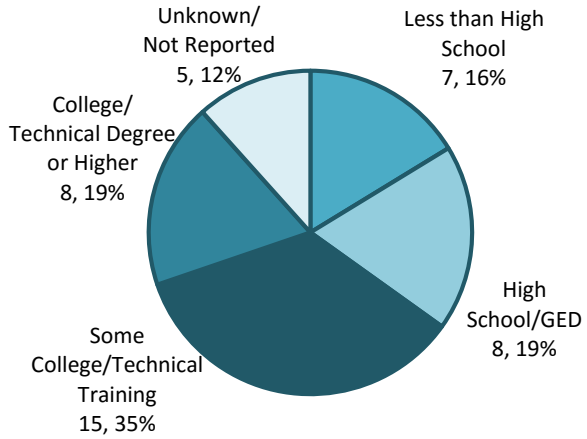
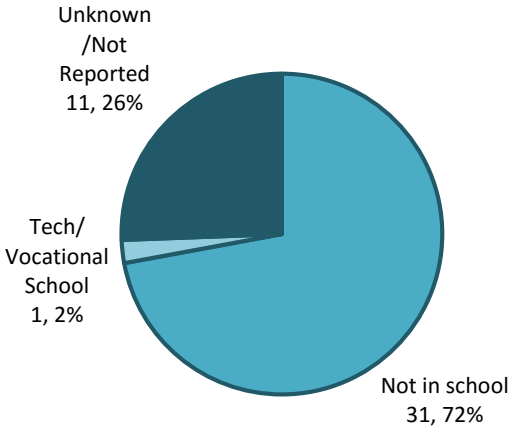


Figure 13. School Attendance at Enrollment (N = 43)



The majority of ACT consumers (81%, n = 35) were not employed when they enrolled, while 16% (n = 7) did not report their employment status. Obtaining employment was a recovery goal for just over half (53%) of AOT consumers, and as shown in Table 8, most consumers (54%, n = 23) received Supplemental Security Income as their primary source of financial support. Additionally, almost all ACT consumers received the same financial support at the time of enrollment as they had in the year leading up to enrollment.

Table 8. Sources of Financial Support at and before ACT Enrollment (N = 43)

Financial Support	Support Received in the Year Prior to ACT Enrollment	Support Receiving at ACT Enrollment
Family Member/Friend	9% (n = 4)	9% (n = 4)
Retirement/Social Security Income	5% (n = 2)	5% (n = 2)

Financial Support	Support Received in the Year Prior to ACT Enrollment	Support Receiving at ACT Enrollment
Supplemental Security Income	54% (n = 23)	54% (n = 23)
Social Security Disability Insurance	2% (n = 1)	0% (n = 0)
Other (including Housing Subsidy, General Relief/Assistance, and Food Stamps)	4% (n = 2)	2% (n = 1)
No Financial Support	12% (n = 5)	14% (n = 6)
No Information Reported	14% (n = 6)	16% (n = 7)

Service Participation

The following sections describe the type, intensity, and frequency of service participation, as well as consumers' adherence to treatment while in the ACT program.

Intensity and Frequency of ACT Services

The ACT model is designed to provide intensive community-based treatment, measured by: 1) the *intensity* of services, which is the amount of service an individual receives in a defined time period; and 2) the *frequency* of services, which is how often an individual receives services. ACT teams are expected to provide at least four face-to-face contacts per week for a total of at least two hours of service per week.

The ACT team continues to provide intensive services to consumers.

Although the length of consumers' enrollment varies, ACT consumers were enrolled for an average of 243 days, with an average of 6.5 face-to-face contacts per week lasting a total of about six hours per week (see Table 9), which clearly exceeds the ACT standards for intensity and frequency of services.

Table 9. ACT Consumer Service Engagement (N = 43)

	Average	Range
Length of ACT Enrollment	243 days	4 – 483 days
Frequency of ACT Service Encounters	6.5 face-to-face contacts per week	<1 – 18 face-to-face contacts per week
Intensity of ACT Services Encounters	6 hours of face-to-face contact per week	<1 – 17 hours of face-to-face contact per week

ACT Treatment Adherence and Retention

The majority of ACT consumers (93%) were adherent to ACT treatment during FY16/17.

Consumers were considered "treatment adherent" if they received at least one hour of face-to-face engagement with their ACT team at least two times a week. Only three consumers (n = 7%) did not meet this standard of adherence (see Figure 14 and Figure 15).

Figure 14. Intensity of ACT Contacts per Week

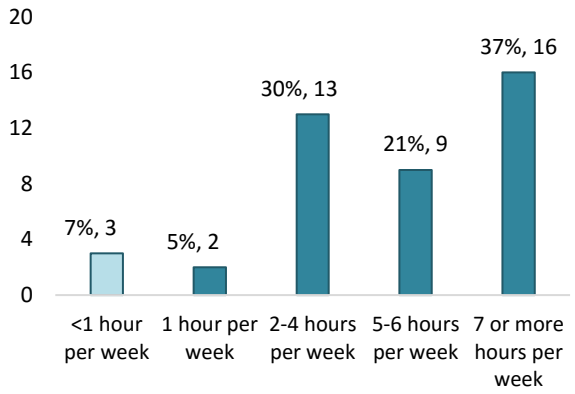
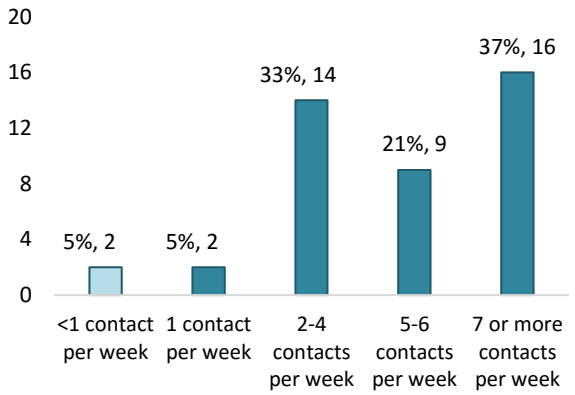
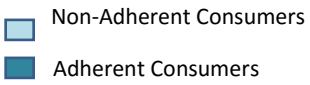


Figure 15. Frequency of ACT Contacts per Week

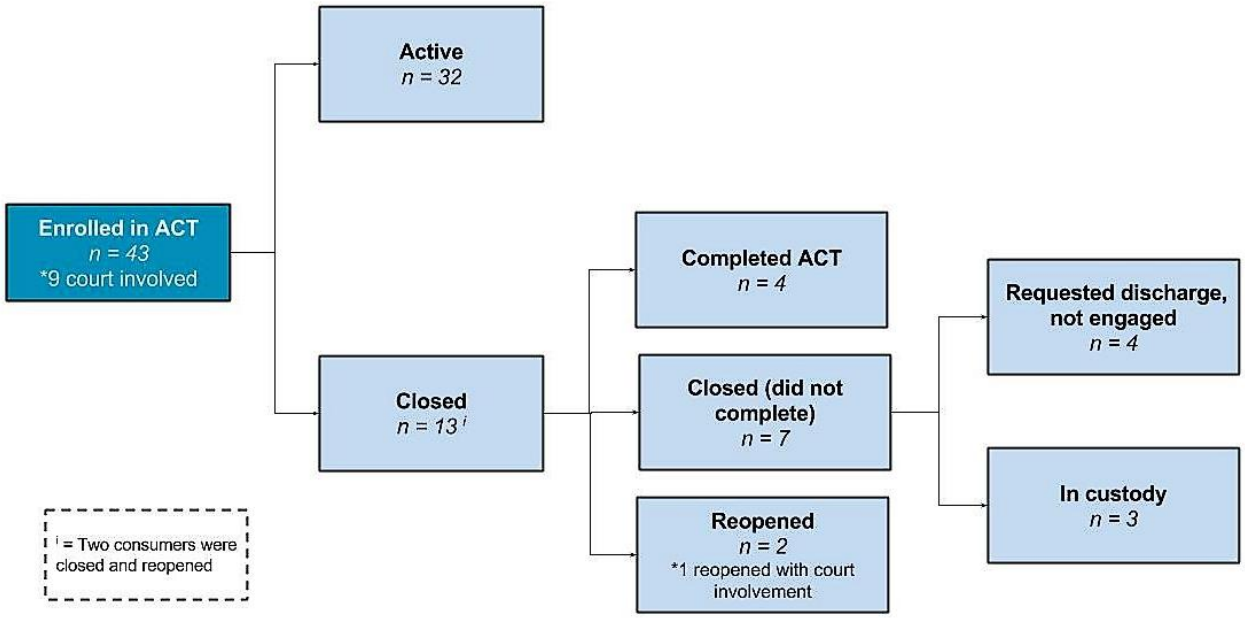




A subset of consumers requested discharge from ACT during FY16/17.

As shown in Figure 16, 30% (n = 13) of consumers were discharged from ACT during FY16/17, two of whom re-enrolled in the program at least once. According to the ACTiOn team, four discharges were the result of successful program completion (e.g., consumers transitioned to a more appropriate level of care or moved out of the area). However, three individuals were discharged because they were incarcerated, while four others were discharged because they were not engaging in treatment. Among these seven consumers, six experienced hospitalization and/or justice involvement following discharge.

Figure 16. ACT Consumers



ACT Consumer Outcomes

The following sections provide a summary of consumers' experiences with psychiatric hospitalizations, crisis episodes, criminal justice involvement, and homelessness before and during ACT enrollment. As previously discussed, these outcomes are standardized to rates per 180 days in order to account for variance in length of enrollment and pre-enrollment data.

Crisis and Psychiatric Hospitalization

This section describes consumers' crisis stabilization episodes and psychiatric hospitalizations before and during ACT enrollment. The County's PSP Billing System was used to identify consumers' hospital and crisis episodes in the 36 months prior to and during AOT enrollment.

On average, the number of consumers experiencing crisis episodes and psychiatric hospitalization, as well as the frequency of those experiences, decreased post-AOT enrollment.

Almost all consumers (93%, n = 40) had at least one crisis episode in the three years before ACT, averaging approximately 4.7 episodes for every six months, with episodes lasting an average of just under two days. Fewer consumers had a crisis episode during ACT (58%, n = 25) with an average of 3.1 episodes for every six months (see Table 10).

Table 10. Consumers' Crisis Episodes before and during ACT

Crisis Episodes		
	Before ACT enrollment	**During ACT enrollment**
Number of Consumers (N = 43)	n = 40	n = 25
Number of Crisis Episodes	4.7 episodes per 180 days	3.1 episodes per 180 days
Average Length of Stay	1.8 days	1.1 days

Similarly, the number of consumers who experienced a psychiatric hospitalization decreased during ACT. Approximately two-thirds of consumers (67%, n = 29) had at least one hospitalization in the three years before ACT, compared to 30% of consumers who experienced a hospitalization during ACT. Those with at least one hospitalization before ACT averaged approximately 1.3 hospitalizations every six months, lasting an average of just under ten days. Though consumers had fewer hospitalizations (1.1 per 180 days) while enrolled in ACT, the average length of stay increased substantially from 9.7 to 28.6 days (see Table 11).

Table 11. Consumers' Psychiatric Hospitalizations before and during ACT

Psychiatric Hospitalizations		
	Before ACT enrollment	**During ACT enrollment**
Number of Consumers (N = 43)	n = 29	n = 13
Number of Hospitalizations	1.3 hospitalizations per 180 days	1.1 hospitalizations per 180 days
Average Length of Stay	9.7 days	28.6 days

Criminal Justice Involvement

This section describes consumers' criminal justice system involvement. Data from the Sheriff's Office and Courts were used to identify their justice involvement in the 36 months prior to and during AOT enrollment.

RDA received the following criminal justice data from Contra Costa County's Sheriff's Office and the Superior Court in order to assess the criminal justice involvement of ACT consumers:

- **Bookings**: Following an arrest, individuals are typically booked into local county jail. Once booked, individuals remain in jail until they are released through bail payment or on their own recognizance.
- **Charges**: The District Attorney's Office determines whether to file charges once a criminal complaint is sought. Charges are a formal allegation of an offense for which an individual is arrested and booked.
- **Convictions**: A conviction is the determination of guilt or innocence (or "no contest") for a given charge following a plea bargain or trial.

RDA received data from the Contra Costa County Sheriff's Office to assess the number of bookings, and average lengths of stay in jail, for each consumer pre- and post-AOT enrollment. In addition, RDA received charges and conviction data from Contra Costa's Superior Court in order to understand the outcomes of consumers' bookings.

The number of consumers experiencing criminal justice involvement decreased during ACT.

The majority of ACT consumers (72%, n = 31) were arrested and booked into county jail at least once in the three years prior to ACT enrollment. During ACT participation, however, only approximately 33% (n = 14) of consumers were arrested and booked. Of those 14 consumers, seven were subsequently charged and four were convicted of a new criminal offense (see Figure 17). Most of the bookings were for probation violations (30%), assault and battery (22%), or trespassing or disorderly conduct (16%).

Figure 17. Criminal Justice Involvement during ACT

Figure 18. Type of Bookings during ACT

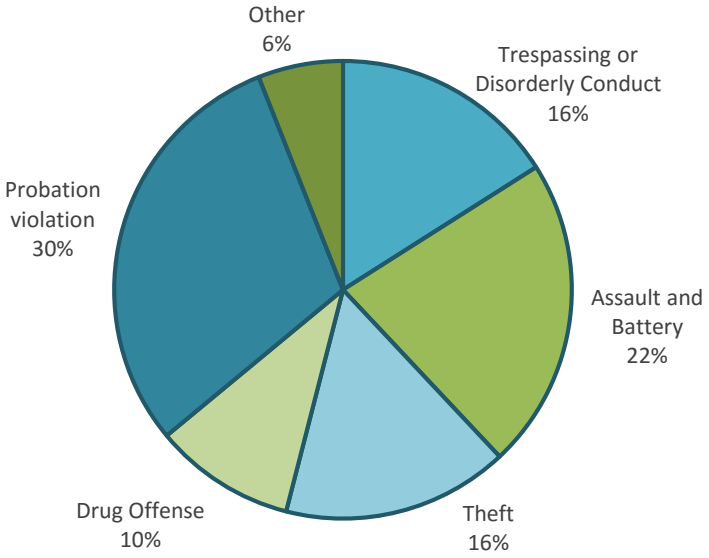


Table 12. Bookings and Incarcerations before and during ACT

Bookings and Incarcerations		
	Bookings before ACT enrollment	**Bookings during ACT enrollment**
Number of Consumers	n = 31	n = 14
Number of Incidents	3.4 bookings per 180 days	3.5 bookings per 180 days

Housing

In addition to improving consumers' mental health outcomes, ACT services are also designed to support consumers in attaining suitable housing situations that support their community mental health treatment.

The majority of consumers (64%, n = 25) either obtained or maintained housing while in ACT.

Self-reported housing data from before and during ACT were available for 39 of the 43 ACT consumers. As shown in Figure 19, the majority of consumers either obtained housing while in ACT (15%, n = 6) or maintained their housing from before ACT (49%, n = 19). Just over one-third of consumers (36%) either lost their housing (8%, n = 3) or continued to be homeless while in ACT (28%, n = 11).

Figure 19. Consumers' Housing Status before and during ACT (N = 39)

Consumers who obtained housing	Consumers who maintained housing	Consumers who were not stably housed
• 15% of consumers who were not housed before ACT obtained housing while enrolled	• 49% of consumers who were housed before ACT continued to maintain housing while enrolled	• 8% of consumers were housed before ACT but did not maintain housing during ACT • 28% of consumers were not housed before or during ACT enrollment

A small group of consumers continues to experience difficulty.

Thirty percent (30%, n = 13) of enrolled consumers continued to struggle with psychiatric hospitalizations and/or criminal justice involvement, and experienced an increase in the rate of these events while enrolled in ACT. Of these 13 individuals:

- Almost half (46%) are TAY,
- Half (50%) are homeless and/or unstably housed,
- Almost all (92%) have a psychotic or mood disorder and a co-occurring substance use disorder, and
- The majority (85%) enrolled in ACT voluntarily.

Social Functioning and Independent Living

Consumers' abilities to function independently and participate in activities that are a part of daily living are also of key importance in ACT programs.

ACT consumers experienced slight increases in their self-sufficiency while enrolled in ACT.

Throughout consumers' enrollment in ACT, the team administers the Self Sufficiency Matrix (SSM) to assess consumers' social functioning and independent living. The SSM consists of 18 domains scored on a scale of one ("in crisis") to five ("thriving"). Clinicians assessed consumers at intake, every 90 days, and upon discharge. Intake data was available for 27 consumers, 21 of whom also had at least one reassessment. Table 13 reports the average scores for consumers at intake, 90 days, 180 days, and one year; "n/a" indicates where no scores were given for those domains.

Table 13. Self Sufficiency Matrix Scores

Domain	Intake Average Score	90-Day Average Score	180-Day Average Score	1-Year Average Score
Housing	3.00	3.57	3.20	4.25
Employment	1.15	1.24	1.27	1.50
Income	1.96	2.57	2.67	3.50
Food	2.65	3.24	2.67	4.00
Child Care	n/a	n/a	n/a	n/a
Children's Education	5.00	5.00	n/a	n/a
Adult Education	3.70	3.67	3.60	4.50
Health Care Coverage	4.07	4.10	3.87	4.50
Life Skills	2.89	3.38	3.53	3.75
Family/Social Relations	2.26	4.19	3.07	4.25
Mobility	2.15	2.71	2.80	4.00
Community Involvement	2.44	3.20	3.13	4.75
Parenting Skills	4.00	2.00	4.00	n/a
Legal	3.67	3.90	3.93	4.25
Mental Health	2.07	2.29	2.73	4.00
Substance Abuse	3.19	3.48	3.20	4.00
Safety	3.70	4.00	4.21	4.50
Disabilities	2.40	2.30	2.62	4.00
Other	1.00	n/a	n/a	n/a
Total Score	41.15	48.14	45.87	59.75
Sample Size	27	21	15	4

Consumers' average scores across domains at the 90-day, 180-day, and one-year SSM administrations were higher than the average intake scores.

AOT Costs and Cost Savings

There are a number of expenses associated with Contra Costa County's AOT program. However, there are also cost savings likely to result from decreases in crises, hospitalization, and incarceration. Additionally, the County generates revenue for Medi-Cal eligible mental health services. To analyze AOT-related costs and cost savings, RDA collected cost-related information from the CCBHS Finance Department, as well as from other County departments involved in the implementation of AOT.

The sections below provide a preliminary review of costs associated with AOT program implementation, as well as the extent to which AOT has generated revenue through Medi-Cal billing and reduced hospitalizations and justice involvement.

The cost to Contra Costa County for implementing AOT in FY16/17 was $1,872,390, which includes actual expenses and revenue projections.

AOT Expenses

During FY16/17, AOT implementation cost Contra Costa County approximately $2,144,226 (see Table 14). CCBHS spent a total of $1,960,001, with $378,195 for Forensic Mental Health to investigate referrals, and $1,581,806 paid to Mental Health Services as the contracted provider delivering the ACT program.

In addition to CCBHS' costs, the County also reported AOT-related expenses incurred by the County Counsel, the Office of the Public Defender, and the Superior Court in supporting the court proceedings element of the AOT process. Costs to County Counsel included providing consultation services for CCBHS, preparing and filing all petitions to the Court, and representing the County in Court hearings. The Office of the Public Defender has one part-time employee who represents all AOT clients, and the Superior Court is responsible for holding AOT court hearings each week.

Table 14. Contra Costa County Department Costs

County Department	FY 16/17 Cost
CCBHS (including FMH and MHS)	$1,960,001
County Counsel	$68,347
Public Defender's Office	$112,500[5]
Superior Court	$3,378.00
Total County Costs	**$2,144,226**

AOT Revenue

The County estimated that they would receive 35% (accounting for a 15% disallowance rate) in revenue from Medi-Cal billing, or $206,589. In actuality, MHS provided approximately $776,675 worth of Medi-Cal eligible services during this time period, and the County estimates that they will receive approximately $271,836 in revenue from Medi-Cal billing for these services. It is worth noting that the County's AOT program only served 43 consumers during FY16/17, and has the capacity to serve up to 75 clients as currently configured; the amount of revenue generated through service provision should continue to grow as the AOT treatment program enrolls more individuals.

Cost Savings

Service costs were estimated for all ACT consumers enrolled in the program for more than 90 days (n = 37). Data sources included PSP billing data and bookings data from the Contra Costa County Sheriff's Office. PSP billing data included a charge for each mental health service, while booking costs were estimated using a projected cost of $106 per consumer per day.[6] As shown in Table 15, the overall costs of mental health services increased; however, the cost of bookings and corresponding jail stays have decreased. This confirms that the County has increased its investment in the well-being and recovery of

[5] Public Defender costs include staff benefits.
[6] Grattet, R. and Martin, B. (2015). *Probation in California*. Retrieved on August 24, 2017 from http://www.ppic.org/publication/probation-in-california/.

consumers, which has led to better outcomes for consumers and a reduced burden on institutions like Inpatient Unit 4C and the County's jails.

Table 15. Mental Health Service and Booking Costs before and during ACT (N = 37)

	Actual Cost		Average Annual Cost per Consumer	
	12 Months before ACT	During ACT	12 Months before ACT	During ACT
All Behavioral Health Services	$2,315,254	$2,685,812	$82,788	$95,699
Bookings	$101,018	$57,028	$7,807	$2,450
Psychiatric Hospitalizations	*$870,157*	*$478,765*	*$69,715*	*$56,512*

It is also important to note that while there are cost savings associated with reducing incarceration and hospitalization for the 43 AOT enrolled consumers, the County is still incurring expenses for a 75 person AOT program. This means that funds are being expended based on an expected enrollment of 75 consumers, while only 43 consumers are receiving services that are likely to reduce incarceration and hospitalization expenses.

Discussion and Recommendations

This FY16/17 evaluation of Contra Costa County's AOT program recognizes the shared efforts of CCBHS, County Counsel, Office of the Public Defender, the Superior Court, and MHS in identifying, engaging, and serving AOT consumers, as well as the Board of Supervisors and community of stakeholders who continue to invest in the success of this program. The following discussion summarizes consumer accomplishments and implementation successes since program inception, and includes recommendations for the County to consider around engaging individuals who are difficult to locate, as well as how to more effectively use the civil court process to compel participation.

CCBHS FMH and MHS work together to identify, outreach, and engage eligible consumers in order to enroll them in ACT.

CCBHS FMH and MHS continue to build their collaborative processes to ensure that appropriate consumers are identified and connected to services. Both teams are persistent in their efforts to work with consumers who may be — by the nature of their diagnoses and co-occurring substance use disorders — difficult to find and engage. Both investigation and outreach and engagement data indicate that the Care Team are meeting consumers "where they're at" and are continuously striving to find and engage consumers and consumers' support networks. The Care Team is consistently outreaching to consumers and their families at a variety of locations and with diverse team members in order to both determine consumers' eligibility for AOT and engage consumers in AOT treatment services.

Contra Costa County's AOT program has engaged 46% of all AOT referrals in the appropriate level of mental health services.

Together, CCBHS FMH and MHS resolved 142 referrals in FY16/17, with 35 referred consumers either still under investigation to determine eligibility for AOT or receiving outreach and engagement in order to connect them to AOT treatment services. Of the 142 referrals closed during FY16/17, 43 engaged with MHS' team, either voluntarily or through the AOT court process. Another 23 consumers were not eligible for AOT and were instead connected to another service provider. Thus, 46% (n = 66) of all referred consumers were connected to the appropriate level of mental health services. The subset of 23 referred consumers who engaged in services other than AOT treatment after referral indicates that AOT provides an additional pathway into the mental health system that benefits more consumers than those who are AOT-eligible.

The majority of consumers experienced benefits from participating in the AOT treatment program.

Consumers experienced a range of benefits from their participation in ACT. Not only did fewer consumers experience crisis episodes, hospitalizations, and justice involvement while in the AOT treatment program, but those who experienced these outcomes both before and after ACT enrollment did so with less severity while enrolled in the AOT treatment program. Further, consumers' average scores on the Self-Sufficiency

Matrix (SSM) reassessment were higher than their average scores at intake, suggesting that consumers are improving in their social functioning and independent living skills through program participation.

A group of individuals referred to AOT were unable to be located during the investigation or outreach and engagement processes.

CCBHS receives AOT referrals for individuals in confined settings (e.g., hospital, jail) as well as the community. Referrals for consumers in the community present a unique challenge, because AOT consumers are likely to be homeless, unstably housed, or otherwise difficult to locate. Other large California counties implementing AOT, such as Orange County, also experience similar difficulty in locating referred consumers who are homeless or unstably housed.

Eighteen (18) individuals who were unable to be located either by CCBHS FMH during the investigation process or by MHS during the outreach and engagement phase experienced a crisis episode or hospitalization following the referral. Of the consumers unable to be located by FMH, seven consumers experienced a hospitalization post referral. Of the consumers unable to be located by MHS, 11 consumers experienced a crisis and seven consumers experienced a crisis episode or hospitalization. Some of these experiences occurred while the referral was open to FMH and/or MHS and some occurred after the referral had been closed.

FMH attends the weekly case conference at the Contra Costa Regional Medical Center (CCRMC) Inpatient Unit 4C to determine if there are any individuals with open investigations at the hospital so that they can assess and engage the individual during their stay. However, FMH does not currently have a way to determine if there are previously referred individuals now hospitalized in order to re-open the investigation. While the FMH clinicians may remember some of the individuals referred, the volume of individuals they investigate likely requires additional tracking mechanisms. It may be useful for CCBHS to develop a mechanism that would allow Psychiatric Emergency Services (PES), Inpatient Unit 4C, and jail mental health to make FMH or MHS aware of an AOT-referred individual's presence at their unit with enough time available for FMH or MHS to be able to conduct an assessment or outreach visit. This may be more difficult at PES where the length of stay is much shorter, which would require that FMH or MHS become aware of the person's presence at PES as soon as possible following entry rather than waiting until discharge.

As such, suggested options could include:

- A tracking mechanism on the face sheet to note an open or previous AOT referral.
- Training for PES, Inpatient Unit 4C, and jail mental health staff to screen for AOT with a process to contact FMH or MHS when a potentially AOT-eligible individual shows up.
- Education for qualified requestors, including family members, to call FMH or MHS to alert them that the individual is at PES, hospital, or jail so that they can go to the facility and make contact.

It might also be useful to build an automated alert within PSP so that MHS and/or FMH receive a notification if one of the referred individuals has an episode opening at PES, hospital, or jail mental health.

Additional exploration of the court's role in AOT may assist with compelling participation in treatment.

During each stage of the AOT process, there are opportunities to assertively engage and compel participation. It may make sense for the County to consider the role of the AOT court petition in increasing the number of eligible individuals who enroll in ACT treatment, decreasing the length of time to enrollment, and increasing retention in AOT treatment in the following circumstances:

- While the person is hospitalized and/or incarcerated;
- If the person is unlikely to engage within 120 days;
- If the person voluntarily agrees to participate but fails to engage or requests discharge prematurely; or
- If the person voluntarily agrees to participate but continues to experience crisis, hospitalization, and/or criminal justice involvement.

This set of recommendations is based on aggregate analyses presented throughout this report and is not informed by a review of individual cases. Nothing in this discussion is intended to question the independent, clinical judgment of the professionals working within Contra Costa County's AOT system. Rather, this discussion suggests that there may be additional opportunities to consider how the petition may be useful to address some of the gaps noted in this evaluation report.

Appendices

Appendix I. AOT Eligibility Requirements[7]

In order to be eligible, the person must be referred by a qualified requestor and meet the defined criteria:

- The person is 18 years of age or older.
- The person is suffering from a mental illness.
- There has been a clinical determination that the person is unlikely to survive safely in the community without supervision.
- The person has a history of lack of compliance with treatment for his or her mental illness, in that at least one of the following is true:
    a. At least 2 hospitalizations within the last 36 months, including mental health services in a forensic environment.
    b. One or more acts of serious and violent behavior toward himself or herself or another, or threats, or attempts to cause serious physical harm to himself or herself or another within the last 48 months.
- The person has been offered an opportunity to participate in a treatment plan by the director of the local mental health department, or his or her designee, provided the treatment plan includes all of the services described in Section 5348, and the person continues to fail to engage in treatment.
- The person's condition is substantially deteriorating.
- Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure the person's recovery and stability.
- In view of the person's treatment history and current behavior, the person is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to himself or herself, or to others, as defined in Section 5150.
- It is likely that the person will benefit from assisted outpatient treatment.

[7] Welfare and Institutions Code, Section 5346

Appendix II. Description of Evaluation Data Sources

CCBHS AOT Request Log: This spreadsheet includes the date of each AOT referral, as well as the demographic characteristics of each individual referred to AOT and the initial disposition of each referral (e.g., unqualified requestor, open AOT investigation, voluntarily accept MHS services, court involved MHS participation) and an updated disposition if the investigation outcome changed.

These data were used to identify the total number of referrals to the County's AOT program during FY16/17, as well as the number of individuals who received more than one AOT referral.

CCBHS Investigation Tracking Log: CCBHS staff logged investigation Blue Notes (i.e., field notes from successful outreach events) into an Access form tracking the date, location, and length of each CCBHS Investigation Team outreach encounter. Future reports will also include the recipient of the service (i.e., consumer or collateral) and outcome of the investigation (e.g., consumer no-show or non-billable service). These data were used to assess the average number of investigation attempts provided by the CCBHS Investigation Team per referral.

MHS Outreach and Engagement Log: This spreadsheet tracks the date and outcome of each MHS outreach encounter, including information on who provided outreach (e.g., family partner, peer partner, clinician) to whom (consumer or collateral contact such as friend, family, or physician), and the location and length of each outreach encounter.

Data from this source were used to calculate the average number of outreach encounters the MHS team provided each consumer, as well as the average length of each outreach encounter, the location (e.g., community, secure setting, telephone) of outreach attempts, and the average number of days of outreach provided for reach referral.

Contra Costa County PSP Billing System (PSP): These data track all behavioral health services provided to ACT participants, as well as diagnoses at the time of each service. PSP service claims data were used to identify the clinical diagnoses and demographics of ACT participants at enrollment, as well as the types and costs of services consumers received pre- and during-ACT enrollment (e.g., outpatient, inpatient, residential, and crises), the average frequency with which consumers received ACT FSP services, and the average duration of each service encounter.

FSP Partnership Assessment Form (PAF), Key Event Tracking (KET), and Quarterly Assessment Form (3M): Though the PAF, KET, and 3M are entered into the Data Collection and Reporting (DCR) system, data queries were unreliable and inconsistent; therefore, MHS staff entered PAF, KET, and 3M data manually into a Microsoft Access database. These data were used in this report to generate consumer profile measures and self-reported changes in outcome measures such as homelessness before and during ACT.

MHS Outcomes Files: These files include assessment data for a number of clinical assessments MHS conducts on ACT participants. For the purposes of this evaluation, the Self Sufficiency Matrix (SSM) was used to assess consumers' social functioning and independent living. Future reports will include findings

from the MacArthur Abbreviated Community Violence Instrument to address consumers' experiences of victimization and violence.

Appendix III. FSP Consumer Profile

The following information describes the individuals served by an FSP program in Contra Costa County during FY16/17.

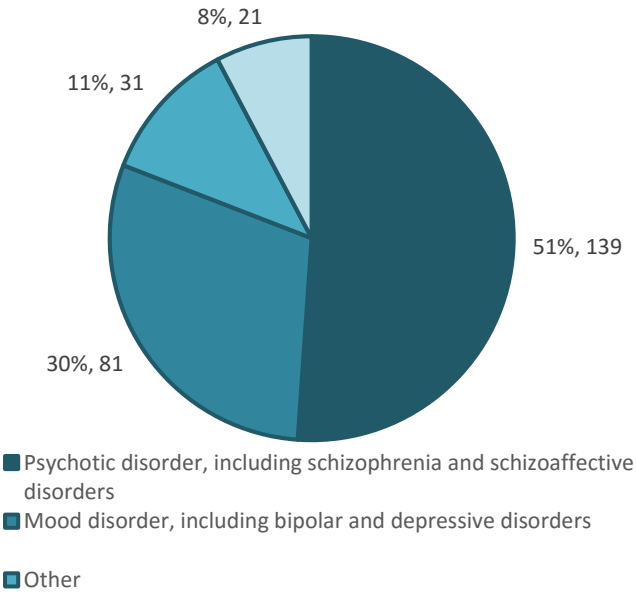
Just over half of FSP clients were male (57%, n = 156) and over half were between the ages of 26 and 59 (60%, n = 162). The majority of FSP consumers were either Black or African American (38%, n = 103) or White (33%, n = 91; see Table 16).

Table 16. FY16/17 FSP Consumer Demographics (N = 272)

Category	ACT Consumers
Gender	
Male	57% (n = 156)
Female	43% (n = 116)
Race and Ethnicity	
Black or African American	38% (n = 103)
Hispanic	18% (n = 48)
White	33% (n = 91)
Other or Unknown	11% (n = 30)
Age at Enrollment	
18 – 25	39% (n = 106)
26 – 59	60% (n = 162)
60+	1% (n = 4)

About half of consumers enrolled in a FSP program in FY16/17 were diagnosed with a psychotic disorder at the time of their enrollment into the program (see Figure 20).

Figure 20. FY16/17 FSP Primary Diagnosis at Enrollment (N = 272)



In the three years before FSP enrollment, just over half of FSP consumers (56%, n = 151) had at least one crisis episode and just over one-third of FSP consumers (37%, n = 100) had at least one hospitalization. Future reports will explore their rates of these experiences before and during FSP enrollment, and will compare appropriately matched FSP consumers to ACT consumers on these outcomes.

Assisted Outpatient Treatment (AOT) Program Evaluation Summary

Resource Development Associates (RDA) completed a first full year evaluation (July 1, 2016 through June 30, 2017) of Contra Costa County's Assisted Outpatient Treatment Program. This program started in March of 2016 to serve seriously mentally ill adults who have demonstrated a resistance to mental health treatment, their condition is substantially deteriorating, and are unlikely to survive safely in the community without supervision. Findings should be considered preliminary due to the program being early in its operations with a resultant small number of consumers included for data analysis.

Methodology. Data was collected from Contra Costa Behavioral Health Services (CCBHS), Mental Health Systems (MHS), the Sheriff's Office, and Superior Court and included 1) the number and type of persons served, 2) frequency and intensity of services, 3) rates of hospitalization, incarceration and homelessness, 4) clinical assessment of change in social functioning and independent living skills, and 5) dollars spent and cost avoided.

Findings.

1) Number and Type of Persons Served. During this period:

- CCBHS investigated 177 persons who were referred, and
    - Determined 42 to meet AOT eligibility and referred to MHS for services;
    - Connected 19 non-AOT eligible individuals with a new or current service provider;
    - Have 25 cases still pending;
    - Closed 91 cases as not being AOT eligible, unable to be assessed, or the referral requestor either withdrew the referral or could not be reached.
- MHS provided outreach and engagement services in a variety of settings to 74 consumers, and
    - Enrolled 34 individuals voluntarily in Assertive Community Treatment (ACT)
    - Enrolled 9 individuals in ACT with court involvement
    - Connected 4 individuals with another service provider
    - Have 10 individuals still receiving outreach and engagement services
    - Closed 17 cases with CCBHS – 4 of whom successfully completed the program
- At the time of ACT enrollment salient features of the 43 individuals include 34 who had a co-occurring substance use disorder, 17 who were homeless or living in a shelter, and 11 who were under the age of 26.

2) Frequency and Intensity of Services. On average the AOT Program took 107 days from referral from a qualified requestor to ACT enrollment, with 17 individuals taking longer than the 120 days called for in the program design. Once enrolled MHS averaged 6.5 contacts per week lasting about 6 hours a week. This is in contrast to the expectation for ACT teams to have at least 4 face-to-face contacts for at least two hours of service per week. 93% of ACT consumers were considered "treatment adherent" by virtue of receiving at least one hour of face-to-face engagement with their ACT team at least two times per week.

3) Hospitalization, incarceration and homelessness rates. Of the 43 enrolled ACT consumers:

- 40 had an average of 4.7 crisis episodes before ACT enrollment, while 25 had an average of 3.1 crisis episodes during ACT enrollment;

- 29 had psychiatric hospitalizations before ACT enrollment, while 13 had hospitalizations during ACT enrollment;
- 31 had bookings and incarcerations before ACT enrollment, while 14 had bookings and incarcerations during ACT enrollment;
- 6 consumers who were not housed before ACT enrollment obtained housing, while 3 lost their housing during ACT enrollment.

4) Clinical assessment of change. MHS clinicians utilized the Self Sufficiency Matrix (SSM) to assess consumers' social functioning and independent living capacity both at intake and at regular intervals of participation in ACT. Average aggregate score increased from 41.15 to 45.87 for the 15 individuals who completed six months of the program, and 41.5 to 59.75 for the 4 individuals who completed one year of the program.
5) Dollars spent and cost avoided.

- For FY 2016-17 Contra Costa County spent $2,144,226 of the $2,250,000 budgeted amount.
- MHS generated $271,836 in Medi-Cal reimbursement, with $206,589 as the target amount.
- Of the 37 consumers with data available, a total of $2,315,254 was spent on all behavioral health services in the 12 months before ACT, while $2,685,812 was spent during ACT, for an increased cost of $370,558. Note that the caseload of MHS is approximately at half capacity.
- Bookings costs decreased from $101,018 to $57,028, for a savings of $43,990.
- Psychiatric hospitalization costs decreased from $870,157 to $478,765, for a savings of 391,392.

Discussion.

1) Both CCBHS and MHS staff work together to persistently and effectively engage and serve consumers who by the nature of their psychiatric disability and co-occurring substance use disorders are difficult to find and engage.
2) AOT program participants experience significant benefits from their participation in ACT.
3) Preliminary cost/savings analysis indicate that significant overall savings to the County can be effected once MHS approximates the 75 consumers they are contracted to serve.

Recommendations.

1) A significant number of referred individuals are closed due to losing contact. It may be useful to develop training and mechanisms to that would allow Psychiatric Emergency Services, Inpatient Unit 4-C, jail mental health, as well as family members and other significant others to make AOT program staff aware of an AOT-referred individual's presence with enough time available for AOT staff to respond.
2) A number of individuals are taking much longer than 120 days from referral to services. The program may wish to consider utilizing the court petition sooner as a means to encourage participation in mental health care.

Contra Costa County Assisted Outpatient Treatment (AOT) Evaluation
Fiscal Year 2016/17 Evaluation Report
Report Addendum #1

Introduction

RDA presented this FY 2016/17 AOT Evaluation report at the AOT Workgroup meeting on September 22, 2017 and at the Family and Human Services (F & HS) Committee meeting on September 25, 2017. In advance of these meetings, CCBHS electronically distributed this interim evaluation report, the annual ACT Fidelity Assessment, a PowerPoint presentation of both reports, and a CCBHS staff summary to an existing mailing list of AOT stakeholders as well as publicly posted the materials on the County website with the agenda for the F & HS Committee meeting. RDA received both written and verbal comments and questions following the AOT Workgroup meeting from stakeholders and AOT partners. The purpose of this addendum is to document stakeholder feedback as well as respond to comments and questions regarding the evaluation. This addendum does not summarize nor respond to questions or comments from the September AOT workgroup and F & HS Committee meetings, as those discussions were documented in meeting minutes.

Below, stakeholder feedback and/or comments are presented in *italics*, followed by RDA's response in indented format.

Stakeholder Communications

Pre-Enrollment

51% of those referred were deemed ineligible, but among the reasons someone would be deemed ineligible are being unable to locate, being unable to get in touch with the referrer, and having the referrer withdraw the referral. I'm not sure I would agree that any of those reasons should be considered 'ineligibility' since the person referred very well could qualify. The reason I think this is important is because by calling them 'ineligible,' it could appear that many individuals who do not qualify are being referred and investigated when in fact much of that percentage may be people who are eligible but go no further in the system due to factors unrelated to their actual eligibility for the program.

> RDA response: In subsequent reports, we can provide information on those who were assessed and determined to be ineligible versus those who were unable to be located.

Do we know how many of those who received services voluntarily through this process were receiving any services prior to referral, or were on the radar of the county outreach teams? This is important information to know because one of the big successes in Los Angeles County has been the avenue into treatment for a population that was not otherwise engaged and had not been engaged with the mental health department prior to referral- meaning that the ability to refer through Laura's Law is the reason these individuals are now receiving treatment, whether they actually qualified for Laura's Law or not. The role of Laura's Law

as a way into the system for those who don't qualify for the program but do qualify for services they were not receiving is important to quantify.

RDA response:

- There is existing data available to the evaluation team regarding whether or not someone participated in mental health services prior to the AOT referral if services were provided by or funded through CCBHS; RDA can explore this information in subsequent reports. Services funded through other county mental health departments, Medicare, private insurance, or other grants would not be included as those data are not available.
- RDA does not have data on whether or not individuals referred to AOT were "on the radar" or receiving services from the County outreach teams as these data are maintained in a separate database. We will explore the feasibility of including this additional data set in the evaluation, if the County would like us to do so.
- The report discusses that 46% (n=66) of AOT referrals were connected to specialty mental health services, including but not limited to AOT. Of the 66 consumers who were connected to mental health services as a result of an AOT referral, 43 engaged with MHS' team, either voluntarily or through the AOT court process and an additional 23 voluntarily enrolled in an appropriate level of mental health services. As discussed in the report, this suggests that "AOT provides an additional pathway into the mental health system that benefits more consumers than those who are AOT-eligible" (page 32).

I would ask that if a person is listed as unable to locate and this person is identified as being seriously mentally ill that these people who have already been identified as being seriously ill by their family, loved one, or health care provider be placed on the a missing person's bulletin. We already do this for people who have autism, Alzheimer's disease, or developmental disabilities. We, however, do not see mental illness as being worthy of such an outreach. Are those unable to be located names turned over to law enforcement for assistance in location?

RDA response: RDA provided this comment to CCBHS and MHS for their consideration regarding referred individuals who are unable to be located. CCBHS shared that they are unable to file a missing person's report, as per county counsel, without a signed Release of Information (ROI). Therefore, this is not something they can do prior to first contact or if the individual does not sign an ROI. Additionally, MHS shared that they do engage in this practice for consumers who are enrolled in the ACT program.

Are other large and similarly size CA counties who have implemented Laura's Law programs experiencing similar 120+ enrollment periods and the referral challenges CCBHS FMH and MHS ACTiOn Team are experiencing?

RDA response: To the best of our knowledge, the average length of time from referral to enrollment in similar sized counties is approximately 2-3 months (i.e., 60-90 days), as compared to Contra Costa's median of 79 days. However, there is a wider range in Contra Costa (4 - 300+

days), and 17 consumers waited for more than 120 days before becoming enrolled in the program (Contra Costa's program design sets forth a 120-day outreach and engagement period for individuals referred). In terms of other referral challenges, other counties are also experiencing difficulties in locating individuals referred to AOT. In this regard, Contra Costa's experience appears similar to other California counties.

Urgent need for PES/4C tracking, greater targeted use of judicial petition, and family requestor documentation training. As a NAMI Family to Family teacher, I teach the importance of proper documentation for "crisis situations." With the new $600K/year Volunteer Network contract, NAMI Contra Costa can collaborate to help improve family requester documentation needed for this program.

RDA response: There are recommendations regarding this point included in the evaluation report.

AOT Enrollment

The researchers appear to call bipolar disorder a mood disorder and schizophrenia/schizoaffective disorder psychotic disorders. Psychosis is obviously a major symptom for many with bipolar disorder, so I probably would not draw that line as it is a fairly artificial distinction.

RDA response: RDA categorized all types of schizophrenia, schizoaffective, and other psychotic disorders as "Psychotic disorders" in the report; all diagnoses listed in the Psychotic disorder chapter of the Diagnostic and Statistical Manual (DSM-V) were included in this category. We included all Bipolar and Depressive disorders in one category labeled "Mood disorder," as was previously categorized in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR). While we understand that psychotic symptoms are frequently associated with Bipolar disorders and the DSM-V separated Bipolar and Depressive disorders into separate chapters, we also look for meaningful categorizations when sample sizes are lower to protect confidentiality. In subsequent reports, we will separate bipolar and depressive disorders, as data permits.

Regarding the small group of consumers who requested discharge from ACT services described on page 24, I disagree with characterizing those who moved out of the area as 'successful program completion.' Further, the indication is that four consumers were discharged from ACT because they were not engaging in treatment, and three were discharged when they were incarcerated. Of those seven, six subsequently were rehospitalized or had justice involvement. My question about this would be why incarceration or not engaging in treatment would be grounds for discharge since they almost all went on to be hospitalized or arrested. Unless I am misreading the data, I believe all seven of these individuals were under AOT orders at the time, so why would they be able to discharge from ACT services by not cooperating- shouldn't this lead to a review and possible rehospitalization? And is there a rule that if someone is arrested or incarcerated they no longer receive ACT services? I think more detail is needed on those seven individuals to understand this.

RDA response: For the individuals who moved out of the area, RDA is unable to provide additional information about their specific circumstances. RDA categorized their discharges as "successful program completion" as part of the case review for the ACT fidelity assessment. However, we understand the commenter's concern about the implications of categorizing data in this way. In future reports, we can consider categorizing this type of discharge as "planned" versus "successful program completion" given that these were planned discharges rather than someone "disappearing."

The majority of the seven individuals, who either requested discharge prematurely or were incarcerated, enrolled in ACT voluntarily and did not have a settlement agreement or AOT order with the court. RDA recommended (page 34) that the County explore how to best leverage the court's role to compel participation. Specifically, RDA suggested:

"It may make sense for the County to consider the role of the AOT court petition in increasing the number of eligible individuals who enroll in ACT treatment, decreasing the length of time to enrollment, and increasing retention in AOT treatment in the following circumstances:

- While the person is hospitalized and/or incarcerated;
- If the person is unlikely to engage within 120 days;
- If the person voluntarily agrees to participate but fails to engage or requests discharge prematurely; or
- If the person voluntarily agrees to participate but continues to experience crisis, hospitalization, and/or criminal justice involvement."

85% of the individuals who were struggling with ACT compliance were voluntarily enrolled in ACT services (page 28). It does make me wonder if they would be struggling as much if the voluntary settlement agreements were entered as court orders to make use of the black robe effect. This is considered a best practice, but it has been resisted by many California counties who want to keep services voluntary if a settlement is reached.

RDA response: The individuals who were voluntarily enrolled did not have any involvement with the court and chose to voluntarily enroll prior to a petition being filed. As discussed in the preceding comment, RDA recommended that the County explore how to best leverage the court's role to compel participation, including, "if the person voluntarily agrees to participate but continues to experience crisis, hospitalization, and/or criminal justice involvement."

ACT Fidelity Assessment

Explicit Admission Criteria: *Since CCBHS currently has "front end" investigation, outreach, and initial referral responsibility, why is there a score of 2 on the part of MHS? Why is there the stated need for greater collaboration between FMH and MHS CC ACTiOn Team? Report also states MHS accepts consumers they do not believe meet ACT criteria, including SUD and developmental disabilities. Thank you for explaining.*

RDA response: ACT occurs within a mental health system, and fidelity to the ACT model requires participation from other agencies. MHS believes that they have accepted some consumers who do not meet criteria; however, CCBHS believes that everyone they have referred meets criteria. RDA's impression is that there is a need for increased communication to ensure that MHS understands why CCBHS assesses someone to meet eligibility criteria, particularly if MHS has questions about eligibility.

No Drop Out Policy: *Why did the score decrease to 3 this year from 5 last year? Due to lack of grater targeted use of the judicial petition? Other reasons? Thank you for explaining.*

RDA response: At the time of the 2016 fidelity assessment, consumers had been enrolled for a short length of time, meaning there were not really opportunities to "drop out." With a full year of data and consumers' with longer tenure in the program, there have been consumers who dropped-out, and the drop-out rate meets criteria for a score of 3.

Assertive Engagement Mechanisms: *I'm "scratching my head" with the onus placed on the MHS ACTiOn Team. Since CCBHS FMH is "in charge" of this function, it appears they, not MHS, bear primary responsibility for the great reluctance to use the judicial petition process and judicial non-involvement as the main reasons for this low score. If I am missing something, thank you for explaining further.*

RDA response: As stated previously, ACT occurs within a mental health system, and fidelity to the ACT model requires participation from other agencies. The ACT model expects that ACT teams use all legal mechanisms available to compel participation, including but not limited to AOT. When discussing the fidelity scores with MHS, RDA suggested that, during MHS' daily team meetings, the ACT team should consider when a petition may be appropriate for individuals in outreach and engagement or for individuals enrolled in ACT. This information should be formally communicated to CCBHS. Once someone is engaging with MHS, CCBHS may not know if nor when a petition may be appropriate and relies on MHS for that information. As a result, this score requires that MHS and CCBHS work together to ensure that CCBHS has the necessary information following referral to MHS for those who might benefit from a petition being filed.

Consumer Outcomes

Hospitalization: *Why did the average length of hospital days increase from 9.7 pre ACT to 28.6 days during ACT? Reluctance to use judicial petition process in an earlier targeted way?*

RDA response: The number of consumers who experienced any hospitalization decreased from 29 individuals before ACT enrollment to 13 individuals during ACT enrollment. However, the length of hospital stays increased from 9.7 to 28.6 days. RDA's interpretation is that the program is helping reduce "avoidable hospitalizations" and that the smaller group of individuals hospitalized during enrollment were likely experiencing severe symptoms and required that level of care and length of time to stabilize and be safe.

Have we explored not only LPS conservatorship but also temporary conservatorships (e.g. T-Con) in the data? Would we know if that had happened, either before enrollment or after?

> RDA response: Conservatorship data that occurred during ACT enrollment is currently available to the evaluation team for LPS and other types of conservatorship. RDA will need to confirm that the pre-enrollment data includes LPS and other types of conservatorship. Where relevant and if available to RDA, we will include in subsequent reports.

Criminal Justice Involvement: *What are the differences in public safety with regards to criminal justice involvement? Do we have any information about those determines to be incompetent to stand trial (IST) post arrest? How can we track information about those individuals who are determined to be IST and receive competency restoration, particularly at the state hospital? Those individuals would not be sentenced but are still in the criminal justice system? Can MHS stay involved with those individuals who are determined to be IST or who are incarcerated?*

> RDA response: This is the first report where data from the courts and Sheriff's Office have been included. Subsequent reports can explore the different charges and convictions, as that may help us understand threats to public safety. Additionally, RDA does have information about someone being sent to a state hospital for competency restoration and that information would be included in the report if it had occurred. However, we did not include information about IST if they were referred to FMH for competency restoration in the community. We will explore the feasibility of including these data in subsequent reports with CCBHS. In terms of remaining in ACT if determined to be IST or incarcerated, it is our understanding that there are individuals enrolled in ACT who were determined to be IST, were referred to FMH for competency restoration in the community, and did remain enrolled in ACT. It is also our understanding that individuals who are incarcerated and are likely to have been released from jail within the six month term of ACT/AOT enrollment were able to stay involved with ACT, and the ACT team meets with them at the County jail. However, there were individuals who were discharged from the program because they were likely to be incarcerated for at least six months. Given that AOT enrollment is for a six-month, renewable term, this appears to be a reasonable cut-off for determining whether or not to continue with a person's ACT/AOT enrollment.

Homelessness: *It was mentioned at the Friday AOT meeting that some people with a mental illness prefer being homeless. I feel that this is a misrepresentation of what these people seek. When interviewed they prefer to be homeless rather than being warehoused in shelters, substandard Room & Boards or bed bug infested apartments. When someone with a mental illness is homeless it is necessary for a deep assessment to be done. Why are they homeless--is it due to their psychosis? It is almost impossible to attain wellness when one is homeless.*

> RDA response: RDA has shared this feedback with CCBHS and MHS.

Outcomes were better across the board for those under AOT orders.

RDA response: While RDA does not yet have a large enough sample size to compare outcomes between those who voluntarily enrolled versus those who enrolled with court involvement, we recommended in our report that the County explore how to best use the petition to promote service enrollment, retention, and expected outcomes.

Cost

Reimbursed treatment expenses well-exceeded what was estimated and cost savings across budget lines (mental health versus corrections) did materialize as was argued. Why does this particular report at N=43 emphasize costs over cost avoidance savings? The 6 month report stated preliminary hospital savings of $1M annualized at N=17.

RDA response: The program did produce reductions in hospitalization and incarceration, both of which are primary drivers of cost decreases. However, it is RDA's perspective that the overall program did not produce anticipated cost savings because 1) the ACT team is funded for a 75-person capacity but has not yet been more than half full, and 2) there is a group of individuals who experienced increases in hospitalization and/or criminal justice involvement. For the first point, the ACT team itself has a higher per person cost. Additionally, we suspect that the individuals who have not yet enrolled in the program continue to experience hospitalization and/or incarceration, which means that the County is, in essence, paying for ACT services for a group not yet receiving them, as well as the hospitalization and incarceration that would likely be reduced if they were enrolled in ACT. For the second point, there is evidence of reduced hospitalization and incarceration for enrolled individuals. However, the report (page 28) discusses that "thirty percent (30%, n=13) of enrolled consumers continued to struggle with psychiatric hospitalizations and/or criminal justice involvement, and experienced an increase in the rate of these events while enrolled in ACT." As a result, there is no reliable way to estimate or predict cost savings at this time because 1) some of the enrolled individuals had increased costs associated with hospitalization and/or criminal justice involvement, and 2) the costs associated with the ACT team are higher than expected because of capacity.

Why have behavioral health service costs increased from 2.3M pre-enrollment to nearly 2.7M post enrollment?

RDA response: RDA expects that this change in actual costs reported is related to a full year of data from program implementation whereas the last evaluation report was produced earlier in Contra Costa's AOT program implementation.

When will the program reach 75 person capacity?

RDA response: RDA has shared this question with CCBHS and MHS.