

Contra Costa County
Assisted Outpatient Treatment
Program Design
June 4, 2015

Introduction

On February 3, 2015 the Contra Costa Board of Supervisors (BOS) directed the Health Services Department to develop an Assisted Outpatient Treatment (AOT) program design with stakeholder participation. **(Appendix A – Board Resolution)**

AOT is civil court ordered treatment for persons with serious and persistent mental illness who demonstrate resistance to participating in services. The proposed program design contained herein complies with the above Board Resolution, and incorporates stakeholder input received in a required Mental Health Services Act (MHSA) Community Program Planning Process, as well as a series of three stakeholder workgroup meetings conducted in April and May of this year. We are most appreciative of the many dedicated and talented individuals who have guided us in this effort. **(Appendix B – Stakeholder Participation)**

California Welfare and Institutions Code (WIC) Sections 5345-5349.5 prescribe eligibility, the legal process and provisions for treatment. Contra Costa's program design adheres to the statute, and this proposed program design addresses the needed complementary procedures in order to implement the law. **(Appendix C – WIC Sections 5345-5349.5)**

It is recognized that AOT is an emerging response in California to our citizens with most challenging mental health issues. As such, implementation of this proposed program design will require attention to applying statute provisions to practice on an ongoing basis to ensure compliance with the law. Also influencing the evolving nature of our program design will be the concurrent efforts of other counties who are developing and implementing their own AOT programs to meet the needs of their citizens.

In response to the Board of Supervisors amended July 9, 2013 motion, Contra Costa Behavioral Health Services (CCBHS) convened the first AOT workgroup to study the issue, compare and contrast various treatment approaches, and provide recommendations to the Board's Family and Human Services Committee. In response to this CCBHS convened another AOT workgroup in 2014 to provide final recommendations to the Board.

For this proposed program design we have incorporated this information, and most notably we have borrowed heavily from the experiences of Nevada County, who have been providing AOT to a small, rural population, and the efforts of San Francisco County, who have been planning to provide AOT services to a densely populated urban area. Our most recent stakeholder workgroup meetings have assisted in the identification of implementation issues that will need to be addressed as we navigate the implementation of AOT in Contra Costa County. **(Appendix D – Issues for Resolution)**

The following **Table of Contents** outlines the areas covered in the program design; namely, the Care Team, Legal Process, Treatment Model, Communicating AOT, the Evaluation Design, an Implementation Timeline, and a Budget Summary.

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The Care Team

This proposed program design is first and foremost a response of compassionate care to both our citizens who are experiencing serious and persistent mental illness, and to their loved ones who are asking for help. This care will be culturally and linguistically appropriate, responsive to the needs of both client and family members, and coordinated into an integrated response for all parties involved. The Care Team is comprised of experienced, highly trained professionals who will provide the first caring response to the referring party, the referred individual, and the referred individual's family and significant others.

The goal of the Care Team is to facilitate voluntary treatment, and to ensure the right treatment services are provided for a referred individual, whether or not it consists of Assisted Outpatient Treatment. Care Team representatives will provide the lead in receiving referrals in the community, conduct outreach and engagement to assist a referred individual, and participate in the investigatory process and development of the treatment plan.

Response

The response of the Care Team to a referring individual will be immediate and provided 24 hours a day, seven days a week. The Care Team will listen empathetically and assist in facilitating a decision by the referring individual as to whether to pursue requesting a petition for Assisted Outpatient Treatment (AOT), or to pursue other levels or types of care. The Care Team will follow the protocol as specified in **Appendix E – Screening, Intervention, Investigation Protocol**. If AOT is to be pursued the Care Team will engage the Contra Costa Behavioral Health Services (CCBHS) Team to initiate an investigation as described in the following section, entitled **Legal Process**. Care Team members, which would normally include Family Partner and Peer Provider staff from the Assertive Community Treatment (ACT) Team, will assist the CCBHS Team throughout the investigatory and legal process. These staff, who are concurrently part of both the Care Team and ACT Team, will be key to providing seamless support to consumers and their loved ones throughout the process; from very first engagement to eventual connection to other levels of care, as appropriate. The Family Partner will be key to setting and communicating goals for family involvement throughout the process.

Outreach and Engagement

Should a petition be requested to pursue AOT the Care Team will assist in the interview of the subject of the request. Law enforcement presence from the appropriate jurisdiction may be requested to serve as a civil standby, should reasonable safety concerns exist. At all times treatment on a voluntary basis will be offered, and connection with the appropriate level and type of care will be pursued. The CCBHS

Team may authorize a representative of the Care Team to initiate outreach and engagement efforts for up to three contacts per week for up to four weeks. More frequent contact may be authorized should the referred individual experience significant further deterioration. All clinical evaluations will be conducted in the least restrictive environment possible. A referred person must meet criteria specified in WIC Section 5150 before a person is transported to the hospital.

Connection and Follow Up to Care

The Care Team has the responsibility for both personally facilitating connection to the right level and type of care, whether contract or county operated. Subject to the provisions of the Health Insurance Portability and Accountability Act (HIPAA), the Care Team follow up with the client, referring party, family and significant others by keeping them informed throughout the AOT process, if appropriate, regarding progress and provisions of care that are being provided or coordinated. Care Team responsibilities also include educating the referred individual as to the process for ensuring that patient's rights are protected, and providing connectivity to advocacy resources.

Team Composition

The Care Team will be led by a licensed mental health clinician representing the CCBHS Team, and will include representation from the ACT Team. The composition of representation from the ACT Team will be flexibly applied to ensure 24/7 response to referral inquiries, optimum professional discipline expertise, cultural and linguistic competency, and consumer and family member lived experience. The usual Care Team composition will consist of a CCBHS mental health clinician, and an ACT Team family partner and consumer peer specialist. Team composition, consisting of both county and contract staff, is designed to improve communication and coordination between the two entities.

Budget and Budget Narrative - The cost of fielding the Care Team is included as part of the Budget and Budget Narratives of the county operated CCBHS Team and the contract provided ACT Team.

Legal Process

Upon the filing of a Request for Petition Contra Costa's legal response adheres to the required steps as specified in WIC Sections 5346 and 5347, and will follow the process depicted in **Appendix E – Legal Process Flow Chart**.

Request for Petition

The process starts when a Qualified Requesting Party submits a written request for the filing of a petition to the Contra Costa Behavioral Health Services (CCBHS) Team.

(Appendix F – Request for Petition)

The CCBHS team is responsible for conducting the investigation and determination of whether a potential client meets eligibility criteria for Assisted Outpatient Treatment.

Investigation

The CCBHS Team, acting on behalf of the Behavioral Services Director, determines whether the requesting party is qualified to request a court petition, and initiates an investigation as to whether the subject of the request is eligible for AOT. The mental health clinician on the CCBHS Team will review all available information, and will personally interview the subject of the request. Law enforcement presence from the appropriate jurisdiction may be requested to serve as a civil standby, should reasonable safety concerns exist. At all times the CCBHS Team will offer treatment on a voluntary basis, and ensure connection with the appropriate level and type of care. The legal process will end at any time the subject of the petition engages voluntarily in services. The mental health clinician on the CCBHS Team may authorize a representative of the Care Team to initiate outreach and engagement efforts for up to three contacts per week for up to four weeks. Additional time and intensity of contacts can be authorized, should an individual's condition deteriorate. The CCBHS Team mental health clinician will verify eligibility by completion of the AOT checklist. **(Appendix G - AOT Eligibility Checklist)**. Completion of this checklist provides the factual basis for establishing beyond any serious doubt that a petition on the client can be proven by clear and convincing evidence. Concurrent with the investigation the CCBHS Team, to include Care Team representatives, will develop or revise a treatment plan that will be utilized as the basis either for voluntary participation or will accompany a court petition. The CCBHS Team will complete its investigation within 30 days of a Request for Petition. The petition can be filed before 30 days of outreach and engagement is complete if significant further deterioration is occurring as documented by the Care Team.

Filing of Court Petition

After written review by County Counsel the CCBHS Behavioral Health Services Director or designee will file a Court Petition within ten days of a CCBHS Team mental health clinician's personal examination or attempted examination of a subject of a Request for Petition. The Court Petition will include a Declaration, a recommended treatment plan, and the completed AOT Eligibility Checklist. **(Appendix H – Court Petition)**

Court Hearing

When the Court Petition is filed the Court will set a hearing date and time not later than five court days from time of filing, and will issue a court summons to appear to required participants, to include the subject of the Court Petition. The public defender becomes the attorney for the subject of the Court Petition at the time the petition is filed. Copies of the Court Petition and a Notice of Hearing will be delivered or sent to the Public Defender, the Patients' Rights Advocate, any current health care provider of the client, and any persons designated by the client. **(Appendix I – Notice of Hearing)** Those persons receiving the Notice of Hearing will be in a position to contact and advise the client.

As a result of the closed and confidential court hearing the judge reviews the information and testimony and determines whether the conditions necessitating AOT are met. Court proceedings should be conducted in a less formal and collaborative manner in order to mitigate the potential traumatizing effects of a courtroom setting that is associated with criminal cases. Should court-ordered AOT be determined the individual can accept or decline to voluntarily engage in treatment. If the individual declines AOT the judge may order the individual to engage in treatment for a period not to exceed six months from the date of the order. Additional six month periods may be authorized should the judge determine that the person still meets AOT criteria.

At any time a 72 hour psychiatric hold may be initiated if the individual meets WIC Section 5150 criteria. However, failure to comply with AOT alone may not be grounds for involuntary commitment or contempt of court findings.

Involuntary medication will not be allowed without a separate court order verifying that provisions of WIC Sections 5332 to 5336 are met.

At intervals of not less than 60 days during the court order the CCBHS Team will file an affidavit affirming the person who is the subject of the order continues to meet the criteria for AOT. At any time a person ordered to undergo AOT may file a Client Petition requiring the CCBHS Team to prove that the person continues to meet AOT criteria. Treatment may not commence until the resolution of the Client Petition.

At any time between the filing for a Court Petition and a resultant court order the subject of a Court Petition may voluntarily enter into an agreement for services. This settlement agreement may not exceed 180 days, is agreed to by all parties, and includes a statement by the CCBHS Team that the person can survive safely in the community.

The CCBHS Team shall monitor the person's compliance with treatment, and will notify the court for a hearing should the person fail to comply with the treatment according to the settlement agreement.

Budget and Budget Narrative

1. Contra Costa Behavioral Health Services (CCBHS) Team.

- Two (2) Licensed Mental Health Clinical Specialists to serve on the Care Team, determine qualified requesting party, conduct AOT investigations, prepare Court Petitions with supporting documentation and ongoing affidavits, testify in Court, coordinate with County Counsel, Public Defender and law enforcement jurisdictions, and act as liaison to Contra Costa Behavioral Health Services county operated and contract provided programs.
- .25 full-time equivalent Mental Health Program Supervisor, to report to and implement the program under the direction of the Behavioral Health Services Director/Deputy Director, Adult System of Care Chief, Program Manager and oversight bodies.
- .25 full-time equivalent Experienced Clerk to support the above activities and collect and disseminate program data and outcomes.

Total Personnel Cost: \$350,000

2. County Counsel.

- .5 full-time equivalent Senior Deputy County Counsel to determine whether AOT criteria are met, research and provide AOT related legal positions, and to prepare, file and serve the Court Petition.
- .5 full-time equivalent Senior Clerk to support the above activities.

Total Personnel Cost: \$157,000

3. Contra Costa Superior Court.

- 1.5 full-time equivalent staff positions required to support the estimated workload associated with 37 cases as an extension of the current Lanterman Petris Short (LPS) court calendar. The Board of Supervisors has authorized the budget to support this staffing level for one year only in order to more accurately determine workload.

Total Personnel Cost: \$128,000

4. Public Defender.

- One (1) part-time Public Defender III and one (1) part-time Legal Assistant position assuming a similar level of involvement as current LPS conservatorship cases.

Total Personnel Cost: \$133,500

Treatment Model

Contra Costa Behavioral Health Services will utilize the Assertive Community Treatment (ACT) model of care. Assembly Bill 1421 cites that fidelity to this model ensures better client outcomes for persons eligible for AOT, and patterned the law's minimum treatment standards on this model.

Assertive Community Treatment is a nationally recognized evidence based practice designed to provide comprehensive psychiatric care, rehabilitation, and support in the community to persons with serious and persistent mental illness. A multidisciplinary team of professionals whose backgrounds include mental health, social work, rehabilitation counseling, nursing, psychiatry and persons with lived experience provide case management, initial and ongoing assessments, psychiatric services, employment and housing assistance, family support and education, substance abuse services and other services and supports critical to an individual's ability to live successfully in the community.

Treatment Goals

The ACT model of care will be implemented by an ACT Team. Each client will have a clearly designated mental health personal services coordinator who is responsible for assessing and providing or assuring needed services according to an agreed upon personal services plan. This plan shall ensure that clients receive age, gender, cultural and linguistically appropriate services, and are designed to enable recipients to:

- Live in the most independent, least restrictive housing feasible.
- Engage in the highest level of work or productive activity.
- Create and maintain a natural support system.
- Access appropriate education and or training.
- Obtain an adequate income.
- Self-manage illness, life skills and decision-making.
- Access physical health care and maintain best possible health.
- Reduce or eliminate antisocial or criminal behavior.
- Reduce or eliminate distress from mental illness symptoms.
- Have freedom from dangerous addictive substances.

Scope of Services

Up to 75 persons who meet AOT eligibility will be served by the ACT Team, regardless of whether they are court ordered or volunteer to participate in services. Services will employ the principles of client-directed psychosocial rehabilitation and recovery, and will primarily be provided out of office in the community by a mobile, highly trained multi-

disciplinary team that use a staff-to-client-ratio of no more than 10 clients per team member. Direct services provided include:

- Outreach and engagement of referred individuals before and during implementation of a treatment plan.
- Participation, as prescribed, on the AOT Care Team.
- Outreach, support and education to families and significant others.
- Mental health treatment, utilizing acknowledged evidence based practices, to include ability to care for patients with long-standing trauma in their developmental history, and who currently suffer from post-traumatic stress disorder (PTSD).
- Access to psychotropic medications.
- Substance abuse services.
- Supportive housing.
- Vocational rehabilitation and access to productive, meaningful activity.
- Benefits and resource counseling and management.
- Access to primary health care.
- Training and education on self-care management, such as Wellness Recovery Action Planning.
- Planning, referral and connection to lower or higher levels of care, as appropriate.

Provision of services will address the special needs of homelessness, physical disabilities, transition age youth, older adults, and, with client consent, will consult with family and other significant persons and designated conservator.

The treatment team will provide monthly progress reports that both qualifies and quantifies progress toward agreed upon outcomes and performance indicators, and supports the CCBHS Team's responsibility for bi-monthly affidavits to the court affirming court ordered clients continue to meet AOT criteria. In addition, the treatment team will provide a yearly report that includes demographic, outcome and program effectiveness information as specified in WIC Section 5348(d).

Budget and Budget Narrative

1. The following personnel will comprise the treatment team:

- One (1) Program Manager who is a licensed mental health clinician.
- Five (5) licensed highly trained behavioral health clinical specialists to perform the role of Personal Services Coordinator. At least one clinician is to be fluent in Spanish, and at least one certified to provide the lead in the delivery of substance abuse services. Services are to be provided 24/7, with approximately 75% of

services to be provided outside the office. Clinicians need to be eligible to bill Medi-Cal, as appropriate.

- One (1) experienced Vocational Rehabilitation Counselor to provide the full spectrum of pre-vocational counseling and employment preparation support leading to significant meaningful activity; such as participation in training, education, volunteer activities, supported or transitional employment, or competitive employment. Will be the team lead in assisting clients obtain and manage benefits and resources leading to self-sufficiency.
- Up to one full-time equivalent (1) Registered Nurse with experience in providing health care to individuals with serious mental illness. Will be the team lead in assisting clients obtain and manage appropriate health care and medications leading to wellness.
- At least 16 hours per week of a board certified Psychiatrist to prescribe and monitor psychotropic medications.
- One (1) Peer Provider with lived experience to assist clients in the self-management and improvement of psychiatric and physical health, life skills and decision-making. Provides emotional support and assists clients with understanding and navigating the Assisted Outpatient Treatment process and connecting to lower levels of care, as appropriate. Assists the Care Team, as called upon, to provide outreach and engagement services.
- One (1) Family Partner with lived experience as a family member of a person with a serious mental illness. Provides emotional support and assists the family and significant others with understanding and navigating the Assisted Outpatient Treatment process, assisting family members and significant others to best support their loved ones in the recovery process, and to coordinate efforts with the ACT Team. Assists the Care Team, as called upon, to provide outreach and engagement services.
- Up to two (2) individuals to provide direct clerical and administrative support, such as office and schedule management, data collection and invoicing.

2. The following represents ongoing and one-time operating costs:

- Flexible funding to directly provide temporary or subsidized housing, transportation assistance, and other goods and services as specified in the treatment plan.
- Ongoing operating costs, such as rent, utilities, communication, training, employee travel costs, equipment and supplies.

One-time start-up costs would be incurred prior to the start of treatment for such line items as retrofitting a facility for staff and client safety and reasonable accommodations,

and one-time purchases, such as furnishings, computers, communications equipment and vehicles.

3. Indirect administrative costs not to exceed 15%.

The County will issue a Request for Qualifications (RFQ) to solicit proposals from community based programs that have the capacity and experience to contract with the County and field the above Assertive Community Treatment Team on a 24/7 basis. The contractor selected would negotiate an annualized budget not to exceed \$1.9 million, and an additional one-time start-up cost not to exceed \$250,000. The following budget is illustrative, and represents an ongoing annualized sample budget:

- Personnel: Up to 13 staff, or 12 full-time equivalent positions = \$1,000,000
- Flexible Funds: client housing and other costs, as specified = 450,000
- Operating Costs: rent, utilities, and other costs, as specified = 200,000
- Indirect Costs: organizational overhead = 250,000

Total Annualized Costs = \$1,900,000

Initial One-Time Start-up Costs = \$250,000

The Contractor will enter into a contract with the County that will stipulate Contractor reimbursement for expenses actually incurred. The Contractor will follow guidelines and procedures to determine client financial liability for services, if any, and produce documentation, to include client charts, in accordance with State policies and procedures for maximizing Medi-Cal, Medi-Care and other insurance coverage reimbursement to the County.

Communicating AOT

Assisted Outpatient Treatment (AOT) in Contra Costa County is relying heavily on the prescriptions of statute, established evidence based practices, and adapting parts of concurrent models of other county behavioral health service systems. The proposed AOT program design is new to Contra Costa County, and as such, requires special initial and ongoing communication efforts in order to appropriately shape the design as it is being implemented, and communicate this program to our stakeholders and the larger community.

Participating Service Providers – Representatives from each of the participating entities, such as CCBHS, legal and court staff, have actively contributed to the proposed program design, and CCBHS will support these representatives to continue regular and ad hoc meetings and communications in order to plan and resolve implementation issues. Additional key entities will be incorporated into this communication network, such as the contractor for the ACT Team, law enforcement jurisdictions, and the evaluation principal investigator, as they are identified. Education of and coordination with potential requesting parties, allied service providers, and other partner resources will need to be identified, with accompanying methods of communication. This communication network can provide support and oversight of the initial bringing together and training of staff who will be working in this new and different pattern of service. In addition, ongoing communication networking with comparable counties implementing AOT will be conducted in order to learn and share strategies, lessons learned, and training opportunities.

Stakeholders – The County's MHSA Community Program Planning Process AOT planning workgroups have contributed input on the proposed program design. Major stakeholder bodies have provided representatives to assist in this effort. These include the Mental Health Commission, the Interagency Homelessness Council, Alcohol and Other Drug Advisory Committee, the Consolidated Planning and Advisory Workgroup, the National Alliance on Mental Illness, and Human Services Alliance. To be developed is a structure and forum for stakeholders to assist in the planning, implementation, evaluation and oversight of the program. This input will need to be coordinated with Contra Costa's current stakeholder efforts, with any additional staff support costs identified.

The Community – Scope and budget of community education and public input efforts with accompanying costs will need to be identified and quantified. This could include communicating in such modes of media as the County's web site, internet venues, newspaper, information and education curriculum, and information materials. It also would include outreach and engagement of non-dominant communities where individuals have been unserved, underserved, or inappropriately served.

It is important that not only the time and costs be determined, but which County entity has lead responsibility. The CCBHS Team staffing pattern as illustrated in this program design does not include staff time and costs for this effort. If CCBHS has lead responsibility, clinical service time will be compromised unless additional staff and resources are allocated to CCBHS.

Budget and Budget Summary – To be determined.

Evaluation Design

Contra Costa County's Board of Supervisors directed that the Health Service Department develop an evaluation design to determine the difference, if any, in program impact and cost savings to the County for individuals who are ordered to participate in services versus those individuals who voluntarily participate in the same level and type of service. The implementation of AOT is a three year term project, with continuance contingent upon demonstration of the efficacy of court ordered outpatient treatment.

Via a competitive Request for Proposal (RFP) process the County will contract with a Principal Investigator who will apply their proposed independent, objective social research design to Contra Costa's AOT Program.

Hypothesis. The Principal Investigator will determine the difference, if any, in program impact and cost savings for individuals served by Contra Costa Behavioral Health Services who:

- Voluntarily participate in treatment with the ACT Team.
- Participate in treatment by means of a court settlement agreement.
- Are court ordered to participate in treatment with the ACT Team.
- Voluntarily participate in a Full Service Partnership program, and are matched with ACT Team participants in level of functional severity.

This hypothesis addresses both whether voluntary versus involuntary participation makes a difference, and whether the newly implemented ACT service delivery has a better program impact and cost savings to the County than existing Full Service Partnership (FSP) programs in the County who are currently serving persons with serious and persistent mental illness.

Method. The total study period will be three years, with three cohorts representing the above groups established. Individuals will be matched by age, gender, race/ethnicity, diagnoses, level of severity of psychiatric disability, income level, and length of active participation in the program. For program and fiscal impact cohorts will be compared at pre- and post-program intervention on the performance and cost indicators of 1) change in level of functioning, to include successful step down to lower levels of care, 2) number and cost of psychiatric crises interventions, such as the County's Psychiatric Emergency Service (PES) 3) days and cost of psychiatric hospital confinement (State and/or local) and incarceration, 4) incidence of engagement in significant, meaningful participation in the community, 5) engagement in conservatorship, and 6) return to previous level of functioning prior to AOT intervention (recidivism). For cost savings cohorts will be compared at pre- and post-program intervention on County dollars spent on each cohort.

Due to the emerging nature of this service, consideration will be given to establishing a start-up phase that enables both major and minor policy and practice adjustments before a study phase is initiated.

Results. Program and fiscal data will be analyzed, with a report constructed to assist decision-making with regard to continuance and appropriate level of funding for respective AOT, ACT and FSP programs.

Budget and Budget Narrative. Via the Request for Information (RFI) process the County will determine the contract fair market value for establishing the cost for completing the evaluation.

Implementation Timeline

The following is an estimate of the earliest dates in which major milestones could be accomplished to implement the AOT program:

<u>Event</u>	<u>Complete by end of</u>
1. Complete stakeholder input process, submit draft program design to County Administrative Office	MAY
2. Board of Supervisors (BOS) approve program design, budget, new County positions	JUN
3. Post Request for Quotation (RFQ) for ACT provider, conduct Request for Information (RFI) for evaluation cost	JUL
4. Award contract to ACT provider, fill county positions, BOS approves evaluation cost, coordinate with law enforcement	SEP
5. Implement training, communication plan for program start, Principal Investigator selected via RFP	OCT
6. Staff in place and program, research design starts	NOV

Budget Summary

<u>Budget Allocation</u>	<u>Fiscal Year 2015-16</u>	<u>Fiscal Year 2016-17</u>
1. Care Team - Costs are included in CCBHS and ACT Team		
2. CCBHS Team – 2.5 County positions	\$350,000	\$350,000
3. County Counsel – 1.0 County positions	157,000	157,000
4. Superior Court - 1.5 County positions	128,000	TBD
5. Public Defender – 1.0 County positions	<u>133,500</u>	<u>133,500</u>
County Positions Sub-total:	768,500	640,500
plus TBD court costs		
6. ACT Team - 13 Contract positions	1,425,000 @9 months	1,900,000
One-time start-up costs	<u>250,000</u>	<u>0</u>
ACT Team Sub-total:	1,675,000	1,900,000
7. Communication – costs to be determined		
8. Evaluation Principal Investigator – costs to be determined		
	*Total Costs: \$2,443,500	\$2,540,500
	plus TBD court costs	

*Does not include Communication and Evaluation costs

Funding Sources**

1. County General Fund – for costs of County Counsel, Superior Court, Public Defender	418,500	418,000
2. MHSA Fund – for costs of CCBHS Team, ACT Team	<u>2,025,000</u>	<u>2,250,000</u>
Total Funding Sources:	\$2,443,500	\$2,540,500
plus TBD court costs		

**Does not include Funding Sources for Communication and Evaluation costs

Funding Revenue

It is estimated that the CCBHS and ACT treatment personnel will generate federal financial participation, or Medi-Cal/Medi-Caid reimbursement, in the amount of approximately 60% of their funding costs on an annualized basis. This amounts to up to \$1,350,000 annually in funds returned to the County.

Appendix A – Board Resolution

THE BOARD OF SUPERVISORS OF CONTRA COSTA COUNTY, CALIFORNIA
and for Special Districts, Agencies and Authorities Governed by the Board

Adopted this Resolution on 01/13/2015 by the following vote:

AYE: ☐
NO: ☐
ABSENT: ☐
ABSTAIN: ☐
RECUSE: ☐



Resolution No. 2015/9

IN THE MATTER OF THE FULL IMPLEMENTATION OF "LAURA'S LAW" (ASSEMBLY BILL 1421):
"ASSISTED OUTPATIENT TREATMENT" IN CONTRA COSTA COUNTY

WHEREAS, the State of California has enacted the "Assisted Outpatient Treatment Demonstration Project Act of 2002", known as Laura's Law, effective January 1, 2003 (Assembly Bill (AB) 1421, Chapter 1017, Stats. 2002); and

WHEREAS, this legislation provides that counties which choose to implement Laura's Law will furnish assisted outpatient treatment services for their residents who meet specified criteria; and

WHEREAS, this legislation provides that no voluntary mental health program serving adults and no children's mental health program may be reduced as a result of the implementation of this program.

NOW, THEREFORE, BE IT RESOLVED ACCORDINGLY BY THE BOARD OF SUPERVISORS THAT:

1. The Assisted Outpatient Treatment Demonstration Project Act of 2002, known as Laura's Law, is operative in Contra Costa County.
2. The Board of Supervisors finds that no voluntary mental health program serving adults and no children's mental health program will be reduced as a result of the expansion of assisted outpatient treatment in Contra Costa County.

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: January 13, 2015

David J. Twa, County Administrator and Clerk of the Board of Supervisors

Contact: Cynthia Belon, 925-957-5201

By: , Deputy

cc: Warren Hayes, Patrick Godley, Cynthia Belon



Contra
Costa
County

To: Board of Supervisors
From: William Walker, M.D., Health Services Director
Date: February 3, 2015

Subject: Implementation of Laura's Law in Contra Costa County

RECOMMENDATION(S):

1. Acknowledge that the Health Services Department has reviewed the adopted Mental Health Services Act (MHSA) three year plan and concluded that \$2.25 million can be redirected to alternative programs.
2. Authorize the implementation of Assisted Outpatient Treatment (AOT) under Laura's Law and direct that no voluntary programs serving adults, and no children's mental health programs may be reduced as a result of implementation of Laura's Law.
3. Adopt Resolution No. 2015/9 to direct the implementation of Laura's Law for a three year period and make a finding that no voluntary mental health programs serving adults, and no children's mental health programs, will be reduced as a result of implementing Laura's Law.
4. Direct the Health Services Department to return to the Board with an amendment to the three year MHSA Plan after soliciting the required community input.
5. Affirm that the Laura's Law implementation is to be a three year term project; continuance to be contingent upon demonstration of the efficacy of court ordered out-patient treatment.
6. Acknowledge a potential unfunded financial liability to continue housing subsidies for individuals who have transitioned into lower levels of care but are still in need of housing subsidies. This unknown ongoing cost would need to be quantified and addressed.

☒ APPROVE

☐ OTHER

☒ RECOMMENDATION OF CNTY
ADMINISTRATOR

☐ RECOMMENDATION OF BOARD
COMMITTEE

Action of Board On: **02/03/2015** ☐ APPROVED AS
RECOMMENDED

☒ OTHER

Clerks Notes: See Addendum

VOTE OF SUPERVISORS

AYE: John Gioia, District I Supervisor
Candace Andersen, District II Supervisor
Mary N. Piepho, District III Supervisor
Karen Mitchoff, District IV Supervisor
Federal D. Glover, District V Supervisor

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: February 3, 2015

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: June McHuen, Deputy

Contact: Cynthia Belon,
925-957-5201

RECOMMENDATION(S): (CONT'D)

>

7. Acknowledge the need to establish the same level and type of services for individuals who meet Laura's Law eligibility for court ordered treatment, but elect to voluntarily engage in services.
8. Direct the Health Services Department to develop an evaluation design that determines the difference, if any, in program impact and cost savings to the County for individuals who are ordered to participate in services versus those individuals who voluntarily participate in the same level and type of services.
9. Direct the Health Services Department to develop a program design with stakeholder participation, and comply with MHSA statutory requirements for a community program planning process.
10. Direct the Health Services Department to pursue any available grant funding to offset the cost of implementing and sustaining the AOT Program.
11. Acknowledge that Laura's Law has a sunset provision and will expire on January 1, 2017, and, in the unlikely event the legislation is not extended as it has been in the past, the matter will be brought back to the Board of Supervisors for further consideration.

FISCAL IMPACT:

Health Services Mental Health:

No County General Fund impact; \$2.25 million MHSA funding is contained within the Health Services Department. Due to the implementation of the Affordable Care Act, the Health Services Department has been able to project downward the total MHSA funds actually needed to sustain Behavioral Health Services staffing costs at the newly opened Cynthia and George Miller Wellness Center (MWC). The MHSA Three Year Plan is now determined to be able to accommodate \$2.25 million of additional programming per year for the next three years without reducing existing voluntary mental health program services.

Public Defender:

Assuming that Laura's Law clients would require a similar level of involvement by the Public Defender as current Lanterman Petris Short (LPS) conservatorship cases, it is anticipated that a similar level of staffing would be needed once the program is fully operational. A total cost of approximately \$133,500 in County General Funds is estimated for one part-time Public Defender III positions and a part-time Legal Assistant position. The Department would need to monitor the workload and make adjustments either up or down after the first year.

County Counsel:

County Counsel has estimated that they will need approximately \$157,000 to implement Laura's Law to fund one half-time Senior Deputy County Counsel and one half-time Senior Clerk position. These costs would be charged back to the Health Services Department. County Counsel tasks will include determination of whether the AOT criteria are met, and the preparation, filing and serving of the petition. The Department would need to monitor the workload and make adjustments either up or down after the first year.

Superior Court:

The Court has provided an estimated cost of \$128,000 based on 1.5 positions required to support the estimated workload associated with 37 cases as an extension of the current LPS court calendar. The Court has indicated that actual costs may be less but until the program is implemented, a more accurate estimate is not possible.

BACKGROUND:

Summary:

On October 7, 2014 the Board of Supervisors (BOS) considered the report from the Contra Costa Health Services Assisted Outpatient Treatment (AOT) Workgroup. The BOS expressed its intention to implement an involuntary assisted outpatient treatment program (also known as AB 1421, or Laura's Law), and instructed the County Administrator's Office (CAO) and Health Services Department to provide additional information in preparation for a January 2015 BOS meeting. Key to the additional information requested was to address whether the BOS could make a finding that no voluntary programs would be reduced as a result of implementing Laura's Law.

On October 28, 2014 the BOS considered and adopted the Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan (Three Year Plan), and directed the Health Services Director to initiate a process to achieve a structurally balanced program budget by the beginning of Fiscal Year 2017-18. They also directed the County Administrator and Health Services Director to report to the BOS at their January 2015 meeting whether current MHSA funds would be available to implement Laura's Law, and what impact this would have on the County's existing voluntary mental health program services.

Accordingly, the Health Services Department has reviewed all elements of the three year MHSA budget to identify areas that need to be updated or modified. The MHSA budget for the Miller Wellness Center was established prior to the implementation of the Affordable Care Act (ACA) on January 1, 2014. The budget assumed normal start-up costs, Medi-Cal billings, and a large percentage of uninsured "Short-Doyle or Basic Health Care" individuals. While the psychiatric portion of the Center has not yet opened, the Health Services Department now has a year of experience with the ACA in other patient care settings. It is clear that the uninsured patient percentage throughout the Department has been drastically reduced over the last year as a result of individuals obtaining health care coverage through the ACA. Accordingly, the Department concludes that the 2015/16 MHSA budget of \$2,750,000 for the Miller Wellness Center is outdated and can safely be reduced to \$500,000 with no impact on the current program design.

The Health Services Department has determined and previously reported that for the next three year period projected MHSA revenues would not keep pace with the projected MHSA budget. This imbalance is due to the expenditure of surplus funds generated from prior periods being used for current period programs. This apparent structural imbalance would eventually exhaust unspent funds from previous years, and would necessitate the modification of programs funded by the MHSA sometime in fiscal year 2018/19 or after. An in-depth program review of the effectiveness of all MHSA funded program is on-going. Programs will be adjusted over time, based upon the evaluated program outcomes, to accommodate available funding. Periodic reports and adjustments may be made as circumstances dictate.

Background Detail:

1. What is Assisted Outpatient Treatment (AOT)?

AOT is civil court ordered mental health treatment for persons with serious mental illness who demonstrate that they are resistant to voluntarily participating in services that have been offered. Treatment is provided in the community on an outpatient basis, and AB 1421, or Laura's Law, has based its minimum required treatment standards on the Assertive Community Treatment (ACT) model. ACT is intensive and highly integrated outpatient treatment for individuals whose symptoms of mental illness result in serious functioning difficulties in several major areas of life, often including work, social relationships, residential independence, money management, and physical health and wellness. An experienced, highly qualified multidisciplinary team consisting of a psychiatrist, nurse, mental health clinicians, peer providers, and other rehabilitation professionals provide 24/7 mobile, out of office interventions with a low participant to staff ratio. ACT is an evidence based practice that is cited by AB 1421 as having been proven to be effective.

2. Who would be eligible for AOT?

Laura's Law, or AB 1421 defines eligibility as adults who suffer from a serious mental illness, 1) are unlikely to survive safely in the community without supervision, 2) have a history of lack of compliance with treatment, 3) due to their mental illness have either been hospitalized or incarcerated at least twice within the last 36 months, or have committed one or more acts of serious and violent behavior toward him/herself within the last 48 months, 4) have been offered treatment commensurate with an ACT level of care but have continued to fail to engage in treatment, 5) whose condition is substantially deteriorating, 6) participation in treatment would be the least restrictive placement necessary to ensure the person's recovery and stability, 7) the person is in need of the treatment in order to prevent further deterioration that would likely result in grave disability or serious harm to him/herself, or to others, 8) would likely benefit from treatment.

3. How many individuals would meet these eligibility criteria?

Contra Costa Behavioral Health Services staff estimate that at any given time approximately 37 individuals would meet the criteria for AOT, and an equal number of individuals would meet the same level of severity but who would likely participate voluntarily in services.

4. Are Counties required to provide AOT?

No. AB 1421, first enacted in 2002, stipulates that Counties may choose to provide AOT by means of authorization from their Board of Supervisors.

5. Why should a County choose to provide AOT?

Proponents, primarily led by parents of adult children who are seriously mentally ill, cite the following reasons:

- Individuals who are gravely disabled by mental illness deny or are not aware of the seriousness of their condition. Consequently, they tend to continue to deteriorate, refuse treatment, and inevitably cause serious harm to themselves, their loved ones, and the community. Enacting Laura's Law breaks that cycle by ensuring the "right to care", and mandating treatment until they can achieve sufficient self-awareness to appropriately make best use of treatment.
- Use of the court system ensures that the behavioral health system is accountable to provide the right level of treatment for individuals who are currently cycling through psychiatric emergency responses.
- Enacting Laura's Law saves the County money by replacing repeated high-cost psychiatric emergency and in-patient hospitalizations with lower-cost out-patient, community-based treatment.
- Enacting Laura's Law saves lives by providing intervention for people who are disproportionately at risk for homelessness, violence, incarceration and death.

6. Why should a County choose not to provide AOT?

Opponents, primarily led by consumers with adverse experience with forced treatment, cite the following reasons:

- Implementing Laura's Law does not provide sufficient protection against potential abuse of the process of involuntary commitment; such as non-mental health professionals initiating the process of forcibly removing someone for evaluation, even if that person has not violated the law.
- Forcible removal of a person from the community by law enforcement can be dangerous, is damaging to the individual, furthers the stigma experienced by people who have a mental illness, and compromises a client's right to confidentiality.
- Out-patient treatment ordered by a civil court has not been proven to be effective long term, and can undermine the powerful positive effects of a provider/client relationship and family/community support built on mutual trust and partnership. Quality, voluntary treatment appropriately applied to a person's unique strengths and limitations has been proven to be effective for persons who are seriously disabled by the effects of mental illness.
- Implementing Laura's Law is expensive in an already underfunded public mental health and County court system.

7. What are other counties doing regarding implementation of Laura's Law?

From a total of 61 possible responses, 46 jurisdictions completed a recent survey, with Contra Costa staff selectively following up for further clarification and analysis.

- 26 are not implementing Laura's Law. Nine Counties have decided not to implement Laura's Law, but have or are enhancing their voluntary services for the most severely disabled by establishing programs that meet the minimum standards for ACT level of services (includes Alameda County). Reasons given for not implementing Laura's Law:
 - o Added voluntary services (usually modeled after ACT) address this population
 - o Lack of funding
 - o Court systems are not capable of handling the increased workload
 - o Board of Supervisors voted no
- 13 are considering implementation, to include Contra Costa County.
- Five have voted to implement, but have not yet started (Los Angeles, Orange, San Francisco, Placer, Mendocino).
- One county, Yolo, has just started a pilot project for up to five individuals to be added on to an existing ACT Team.

- One county, Nevada, reports that they have served 5-10 individuals per year since 2008. They contract out their program to Turning Point at a treatment cost of \$20,000 per person. They estimate that the County saves \$1.81 for every dollar they spend on this program. Funding source for treatment is a combination of Mental Health Services Act (MHSA), Medi-Cal and Medi-Care. Funding source for court costs are County General Fund and State Superior Court funds.

8. How much could Contra Costa save by implementing Laura's Law?

This is unknown. Nevada County reports costs savings (see above), but no county comparable in size to Contra Costa has implemented Laura's Law long enough to determine whether individuals involuntarily participating in outpatient treatment results in either reduced public mental health costs or an overall reduction in public costs incurred by these individuals. The analysis that resulted in an estimate of potentially 37 individuals in Contra Costa being directed to AOT also estimated that these individuals incurred approximately \$1.5 million in yearly public mental health costs associated with psychiatric emergency responses. Primary care and criminal justice costs are unknown.

A rigorous research design is needed, with pre- and post-intervention costs in order to determine the degree of any cost savings.

9. What is the position of stakeholders in Contra Costa County?

Input from individuals receiving, providing, or otherwise actively engaged with public mental health services in Contra Costa County is divided on the issue of whether to implement Laura's Law.

- On March 13, 2014 the Mental Health Commission, who provides oversight on behalf of the Board of Supervisors, voted 8 to 1 in favor of implementing Laura's Law, with 2 abstaining, and 2 individuals not present to vote.
- On July 15, 2014 the Assisted Outpatient Workgroup, commissioned by the Board of Supervisors' Family and Human Services Committee, were asked to indicate their level of support for implementing Laura's Law. The group did not reach a level of consensus. Of the 6 participating consumers and family members of consumers, 5 expressed support for implementing Laura's Law, with one opposed. The remaining 15 county employees and private provider representatives were neutral, and indicated they would support the direction of the Board of Supervisors.
- On August 7, 2014 the Consolidated Planning Advisory Workgroup, who advises the Behavioral Health Services Director, voted 11 to 2 against implementing Laura's Law, with 4 abstaining (county employees) and 5 individuals not present to vote.

However, there was broad consensus from the above groups and the over 500 individuals participating in the MHSA Three Year Program and Expenditure Planning process that an intensive multi-disciplinary service response is lacking for individuals who are most debilitated by the effects of mental illness, and who continue to cycle through the most costly levels of care without success.

10. Are there legal considerations?

Yes.

- Disability Rights California has gone on record with their opposition to AOT, and stated they will legally challenge the implementation of Laura's Law by Los Angeles County. The impact on other counties is unknown. However, a representative of this statewide disability rights advocacy organization entered their opposition to Contra Costa implementing Laura's Law at the October 28 Board of Supervisor meeting.
- Welfare and Institutions Code, Section 5348 (b) (Laura's Law) mandates that "any county that provides assisted outpatient treatment services pursuant to this article shall also offer the same services on a voluntary basis". Contra Costa County currently does not offer a voluntary program that is comparable to the minimum program standards as specified in AB 1421. Implementing Laura's Law would require also establishing the same services for individuals with the same level of disability who volunteer for services.
- As per Welfare and Institutions Code Section 5349, the Contra Costa Board of Supervisors would be required to include in a resolution to implement Laura's Law the statement that "no voluntary mental health program...may be reduced as a result of the implementation of this article".

11. How much is this MHSA structural fiscal imbalance?

Per the 10/28/14 Board report the MHSA fund has a balance of \$49 million, which includes \$7.1 million in "prudent reserve" funds that can only be used when MHSA revenues are insufficient to fully fund existing programs. The MHSA

budget for current year (\$41.6 million) is approximately \$5 million more than estimated revenue (\$36.9 million), and this shortfall escalates to approximately \$10 million annually thereafter. Utilizing these projections it is estimated that, without correction, the MHSA fund balance would be exhausted in five to six years.

12. How close are projected revenues of the County's Mental Health Services Fund versus what is actually received?

Prior to the start of each fiscal year, the State Department of Health Care Services (DHCS) provides estimates to the counties based upon input from the State Controller's Office. For the last five years actual MHSA revenues received from the State exceeded estimates by \$6.7 million, or 4.9% for the five year period. Any revenues received in excess of the projections become part of the fund balance for the next fiscal year, and are considered in the subsequent budget development.

**Contra Costa County MHSA Revenues
(Dollars in millions)**

	FY09/10	FY10/11	FY11/12	FY12/13	FY13/14	Total
Contra Costa Estimated Revenue ¹	\$31.7	\$25.9	\$19.3	\$30.5	\$30.5	\$137.9
Contra Costa Actual Revenue Received ²	\$30.7	\$26.5	\$23.2	\$36.1	\$28.1	\$144.6
Variance	(\$1.0)	\$0.6	\$3.9	\$5.6	(\$2.4)	\$6.7
Variance in Percent	-3.2%	2.3%	20.3%	18.3%	-8.0%	4.9%

Notes:

1) Contra Costa statewide percentage is 2.272674% per MHSA Distribution Ratios per State Controller's Office.

2) Contra Costa Actual Revenue Received reflects amounts received for each program year and not actual deposits to the Trust fund. Does not include interest earned from Trust Account.

13. Are there MHSA funds available in the next three years to fund the above mental health treatment program without reducing current voluntary programs?

Yes. Due to the implementation of the Affordable Care Act, the Health Services Department has been able to project downward the total MHSA funds actually needed to sustain Behavioral Health Services staffing costs at the newly opened Cynthia and George Miller Wellness Center (MWC). The MHSA Three Year Plan is now determined to be able to accommodate \$2.25 million of additional programming per year for the next three years without reducing existing voluntary mental health program services.

14. What is recommended, given the above information and the Board of Supervisor's direction?

- Establish a Laura's Law program as a three year term project, with continuance to be contingent upon demonstration of the efficacy of court ordered out-patient treatment, as well as sufficiency of MHSA funds available to continue the program without causing the reduction of voluntary programs.
- Design the program to concurrently establish the same level and type of services for individuals who meet Laura's Law eligibility for court ordered treatment, but who elect to voluntarily engage in services.

15. How much would it cost to implement the above recommendations?

Resource Development Associates (RDA), the consulting AOT Workgroup facilitator, submitted a report to the Board of Supervisors in October that provided treatment, Superior Court, County Counsel and Public Defender cost estimates for 37 individuals who were ordered to participate in treatment. The report also estimated mental health treatment costs for an additional 76 individuals who voluntarily participated in full service partnerships.

The Board then directed County administration to re-visit the program and fiscal assumptions that RDA used to arrive at these estimates. For example, treatment and court costs were derived by accepting estimates of costs that other counties were using for planning purposes, such as assuming a \$37,500 treatment cost per individual. County staff subsequently engaged in a "zero based budgeting" approach, in which needed line items within personnel, operating and administrative costs were built upon minimum standards prescribed by AB 1421, as well as current staffing and operating costs for various professional disciplines currently funded by Contra Costa County.

As a result of this subsequent analysis Behavioral Health Services staff now indicates that a mental health treatment program meeting the minimum program standards and legal requirements specified in AB 1421 can be implemented for \$2.25 million. This treatment program can serve up to 37 court ordered individuals, and a similar number of individuals with the same level of severity who are the subject of a petition, but who choose to volunteer for services. Thus a single mental health treatment program could serve up to 70-75 individuals who are both court ordered and voluntary.

Costs for non-mental health treatment participation, such as Superior Court, County Counsel, Public Defender and the Sheriff's Office were also subsequently reviewed. Direct Superior Court costs were revised downward to \$128,000, Public Defender costs were revised downward to \$133,500, and County Counsel costs were reduced downward to \$157,000. This reduced the estimated Court, County Counsel and Public Defender costs downward to \$418,500. Additional workload and increased costs to the Sheriff's Department are unknown.

The following factors need to be considered regarding costs:

- If MHSA funds are used as a funding source, a community program planning process is required where stakeholder input would be solicited regarding program design. Costs could vary depending upon the program design that results from this process.
- Housing subsidies committed to and paid for during program participation would potentially be an ongoing County financial responsibility after an individual has moved to a different level of care, as funding would need to be secured to enable individuals to stay in their homes. This unknown ongoing cost needs to be determined as part of the evaluation of program impact and potential cost savings.
- A one-time start-up cost of up to \$250,000 could be incurred prior to the start of treatment for such items as retrofitting a facility for staff and client safety and reasonable accommodation, and one-time purchases, such as furnishings, computers, communication equipment and vehicles.

16. How long would it take before a program could start?

It is estimated that it would take 10 months from Board resolution to start of program services. Major milestones to accomplish would be:

Complete a community program planning process	4 months
Board approves implementing plan and authorizes budget	1 month
Contract awarded to contract provider and/or fill county positions	3 months
Plan for program start, train staff	<u>2 months</u>
Total	10 months

If the Board approves Resolution No. 2015/9, attached to this Board Order, client services could start by November 2015.

CONSEQUENCE OF NEGATIVE ACTION:

If the Board does not approve the recommendations in this Board Order the status quo will be maintained.

CHILDREN'S IMPACT STATEMENT:

Not applicable.

CLERK'S ADDENDUM

Speakers: Martin Fox, Veterans Coalition of San Mateo County (handout attached); Lt. John VanderKlugt, Antioch Police Department and City of Antioch; Don Green, resident of Lafayette; Connie Steers, resident of Concord; Sharon Madison, resident of Walnut Creek; Susan Norwick Horrocks, resident of Orinda; Charles Madison, NAMI CC; Al Farmer, resident of Orinda; Linda Dunn, NAMI Family to Family Teacher; Douglas Dunn, NAMI 1st Vice-President; Margaret Netherby, Interfaith Council of Contra Costa County; Teresa Pasquini, resident of El Sobrante; Clare Beckner, NAMI; Tess Paoli, Mental Health Commission Laura's Law Study Group; Gina Swirsding, resident of Richmond; Lauren Rettagliata, Mental Health Commission; Reverend Will McGarvey, Interfaith Council of Contra Costa County (handout attached). The following did not speak but left written comments for the Board's consideration (attached): Janice Khalil, resident of Brentwood, Anthony Khalil, resident of Brentwood. ADOPTED recommendations and DIRECTED that the program developed with stakeholder participation (see No.9) come back to the Board of Supervisors for final approval at

the end of May; DIRECTED Health Services to return to the Board financial reports following the implementation of the program for use in creating the 2016-2017 budget, and annually thereafter; DIRECTED the County Administrator to build into the 2015-2016 budget the funding for the program implementation with the understanding that the funding for the Court portion is for one year only.

ATTACHMENTS

Resolution No. 2015/9

Appendix B – Stakeholder Participation

This program design plans to utilize Mental Health Services Act (MHSA) funding. In accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations Section 3300 a Community Program Planning Process was completed. A Community Forum was conducted on February 26 as part of the Fiscal Year 2015-16 Update to the MHSA Three Year Program and Expenditure Plan. Input provided by the community is included in this Appendix. In addition, the Plan Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment, and a public hearing was held by the Mental Health Commission on May 14. All input has been considered with adjustments made, as appropriate.

A series of three workgroup meetings were facilitated by Contra Costa Behavioral Health Services staff on April 23, April 30 and May 19 in order to provide input on the design of the AOT program. Invitations to key stakeholder organizations, participating legal entities and care providers were extended. A summary of their input is provided in this Appendix.

February 26, 2015 Community Forum

Implementing an Assisted Outpatient Treatment (AOT) Program

Participants in the community forum provided input on how they would like an assisted outpatient treatment program designed. They responded to the following questions:

- How would you suggest we engage persons who are eligible for AOT?
 - Have a mobile team capable of responding to crisis situations, and capable of determining whether an individual is a threat to him/herself or others.
 - Outreach to potentially eligible individuals needs to be caring and client centered.
 - Outreach staff need to be experienced in recognizing and treating symptoms of trauma, and experienced with persons under the influence of multiple psychoactive substances.
 - Staff need to be competent in responding to unique cultural and ethnic differences. Capacity in non-dominant languages needs to be available.
 - Prioritize engaging those individuals who pose a danger to others.
 - Prioritize those individuals from Contra Costa who are being released from out of county locked psychiatric facilities.
 - Partner with law enforcement and emergency medical treatment (EMT) staff, and ensure they are trained in mental health crisis intervention (CIT).
 - Develop and implement a training curriculum for all staff at potential places of referral regarding AOT and protocol for referral.
 - Train all affected parties on 5150 statute, and follow up to ensure provisions are uniformly applied.
 - Develop positive working relationships with places where potentially eligible individuals would be identified, such as psychiatric emergency services (PES) and inpatient psychiatric hospitalization (4-C).
 - Client rights and the benefits of AOT need to be clearly and consistently communicated.
 - AOT staff should develop a partnership with Adult Protective Services.
 - Multi-media communication of the program should educate the community and positively communicate rights and benefits that reflect actual practice.
 - Outreach should also engage the individual's family and support network to assist the individual participate in treatment.
 - Peer and family provider staff should be available to assist the individual throughout the process, to include system navigation and transportation assistance.

- Establish a staffed AOT hot line, and ensure 211 information is current. Hot line and 211 response should support family members and significant others who are dealing with current and potentially eligible individuals.
- Literature should be available in jails, homeless shelters and other places where potentially eligible individuals reside.
- Keep outreach and engagement records to inform subsequent efforts.
- How would you like the assessment and court process designed?
 - Ensure all parties involved in the court process are trained in AOT.
 - Either use the existing Behavioral Health Court or model the approach after the Behavioral Health Court in Contra Costa.
 - Mitigate the effects of the courtroom environment by considering holding the court process in a more normalized environment.
 - Ensure a multi-disciplinary team is involved in the assessment process, to include primary care, substance abuse professionals and peer and family member providers.
 - Ensure the assessment process evaluates the source of the referral in order to ensure the motivation of the referral source and veracity of information provided supports an appropriate referral.
 - Ensure peer provider support and patient rights advocacy is provided throughout the process. Use volunteers if necessary.
 - The presiding judge(s) is critical. He/she needs to be well trained in AOT, culturally competent and compassionate.
- What services would you want emphasized?
 - Provide services in accordance with the minimum standards specified in the evidence based practice of the Assertive Community Treatment Team model.
 - In addition to mental health treatment and case management services provide housing first, ensure peer and family member supports throughout, quality health care, substance abuse assessment and services, and attention to addressing developmental disability issues.
 - Services need to be trauma informed and culturally and linguistically competent.
 - Staff need to be experienced in connecting to what motivates an eligible individual in order to establish treatment goals and plans in which the individual will actively participate.
 - Involve the consumer's family members and significant others in the treatment process as much as is practicable, with emphasis toward mending relationships and developing natural supports.

Appendix B -1 - Stakeholder Participation

- Include transition planning to ensure the right level of care is provided at the right time, and the consumer is appropriately connected to lower levels of care as they improve.
- Providers need to continually assess potential harm to consumer, family members and staff, and develop protocols to maximize safety.
- Employ stringent confidentiality measures throughout the process, with care toward minimizing stigma and potential further criminalization.
- Make clear the process by which to opt out of treatment and obtain legal representation.
- Establish stakeholder oversight, and develop clear program and fiscal outcome measures.

Laura's Law

Assisted Outpatient Treatment (AOT)

Workgroup Session #1

April 23, 2015



Welcome Stakeholders!

- Consumer perspective
- Family member perspective
- Psychiatric emergency response
- County and contract treatment providers
- Court, legal proceeding participants
- Law enforcement
- Oversight bodies

Workgroup Purpose

- FEB 3 - Board of Supervisors (BOS) directed the Health Services Department (HSD) to develop an AOT program design with stakeholder participation, and comply with Mental Health Services Act (MHSA) statutory requirements for a community program planning process – to be completed by end of MAY 2015
- FEB 26 - Community Forum
 - Input from community received
- APR 23 - Session #1
 - Review information to date and identify areas needing input
- APR 30 - Session #2
 - Discuss identified areas needing input
- MAY 19 - Session #3
 - Review and comment on draft program design

SEP 2014 AOT Workgroup Report

- AOT workgroup met JUN – AUG 2014 with participation from stakeholders regarding engagement of the Laura's Law (AB 1421) target population.
- Researched AOT and made recommendations to the Board in OCT 2014.
 - In Home Outreach Team (IHOT)
 - Psychiatric Emergency and Hospital Transition Program
 - Full Service Partnership Expansion (FSP)
 - Assisted Outpatient Treatment (AOT)
- BOS directed HSD to provide specific information prior to making a resolution.

What Is AOT?

- Civil court ordered treatment for persons demonstrating resistance to participating in services
- Mental health treatment modeled after Assertive Community Treatment (ACT)
 - Experienced, multi-disciplinary team
 - 24/7 mobile out-of-office interventions
 - Low participant to staff ratio
 - Provides full spectrum of services, to include health, substance abuse, vocational and housing services

Who Is Eligible For AOT?

- Seriously mentally ill and 18 or older
- Unlikely to survive in the community without supervision
- History of lack of compliance with treatment
- Due to mental illness, hospitalized or incarcerated at least twice in last 36 months, or committed one or more acts of serious violent behavior to him/her self or others within last 48 months
- Has been offered Assertive Community Treatment level of care but has continued to fail to engage in treatment
- Condition is substantially deteriorating
- Participation in treatment would be the least restrictive placement necessary for recovery
- Needs the treatment to prevent grave disability or serious harm to him/her self or others
- Would likely benefit from treatment

Who is a Qualified Requesting Party?

- Person 18 or older with whom person who is the subject of the petition resides.
- Parent, spouse or sibling over 18
- Director of mental health care institution person resides
- Director of hospital person resides
- Licensed mental health treatment provider of person
- Peace officer, parole, probation officer assigned to person

FEB 2015 Board Resolution

- Implement Laura's Law for a three year term period; continuance to be contingent upon demonstration of the efficacy of court ordered outpatient treatment.
- Budget up to \$2.25 million in MHSA funds to serve up to 75 voluntary and involuntary participants per year for program treatment.
- Establish the same level and type of service for individuals who meet Laura's Law eligibility but elect to voluntarily engage in services.
- No voluntary programs will be reduced as a result of implementing Laura's Law.
- Address and quantify the unfunded financial liability of continuing housing subsidies for individuals who transition into lower levels of care but are still in need of housing subsidies.
- Evaluate program impact and cost savings to the County of voluntary versus involuntary participation in the same level and type of services.
- Develop a program design with stakeholder participation, and comply with MHSA statutory requirements for a community program planning process

FEB 2015 Community Forum Input

- Engaging persons who are potentially eligible for AOT
 - Outreach staff need to be mobile, caring, client centered, culturally and linguistically competent, experienced with symptoms of trauma, multiple psychoactive substances, and capable of responding to crisis situations.
 - Prioritize engaging those who pose a danger to others, and those being released from locked facilities.
 - Develop a positive working relationship with law enforcement, emergency medical treatment staff, psychiatric emergency services , and Adult Protective Services.
 - Engage and support the individual's family and support network; establish an AOT hot line.
 - Peer and family support staff should be available to assist the individual and family members throughout the process
 - Client rights need to be clearly and consistently communicated and honored.
 - Develop and implement a training curriculum and referral protocol.
 - Provide multi-media communication of the program and its benefits.

FEB 2015 Community Forum Input

- Design of assessment and court process
 - Ensure all parties involved in the court process are trained in AOT.
 - Use either the existing Behavioral Health Court or model the approach after the Behavioral Health Court.
 - Consider holding the court process in a more normalized environment to mitigate courtroom effect.
 - Staff involved in the assessment process should be multi-disciplinary, to include primary care, substance abuse professionals, and peer and family members.
 - Evaluate the veracity of the referral source's information.
 - Ensure peer provider support and patient rights advocacy are provided throughout the process.
 - The presiding judge should be well trained in AOT, culturally competent and compassionate.

FEB 2015 Community Forum Input

- What services should be emphasized
 - Provide services according to the ACT model
 - Provide housing first, with health care, substance abuse treatment and the full spectrum of care
 - Services to be trauma informed, culturally and linguistically competent
 - Involve family and significant others, with emphasis toward mending relationships and developing natural supports
 - Staff should know how to connect the treatment plan with what motivates the individual
 - Include transition planning to ensure right level of care as person improves
 - Continually assess potential danger from consumer and develop safety protocols
 - Employ stringent confidentiality measures throughout the process
 - Make clear the process to opt out and obtain legal representation
 - Establish stakeholder oversight, and develop clear program and fiscal outcome measures



Review Legal Workflow

- Welfare and Institutions Code (WIC) 5345-5349.5
- Flow chart architecture adapted from San Francisco Community Behavioral Health Services Model
- Potential workgroup issues for discussion and input:
 1. Eligibility Determination - will (should) a citizen not be eligible for Contra Costa Behavioral Health Services due to private insurance, veteran's status, on parole?
 2. Assessment – will (should) medical records be made available for AOT petition investigation without citizen's informed consent?
 3. Outreach - Is (should) there (be) a limit on outreach efforts to engage a citizen, such as three times a week for up to four weeks?

Review Legal Workflow (2)

4. Decision to File – What information should (is required) to be shared with a qualified Requesting Party? What happens when a requestor disagrees with the decision of the AOT clinician?
5. Examination in the Field – what happens when the AOT clinician determines that an examination in the field is unsafe? Will (should) the Sheriff's Department offer a civil standby?
6. Intervention by Court Order – Will (should) the judge order the Sheriff's Department to transport an unwilling citizen to psychiatric emergency services for evaluation?

Review Legal Workflow (3)

7. Notice of Hearing - Who will (should) personally serve the citizen with the summons to a hearing? This is out of scope for AOT clinician if County employee. Will (should) Sheriff provide civil standby protection?
8. Non-compliance With Treatment – Will (should) the treatment provider request a 5150 for individuals who are not participating in treatment?
9. Benefit from Treatment – Can (should) the AOT clinician determine that the client is not benefitting from treatment due to persistent non-compliance, and recommend dismissal?

Review of Treatment Model

Statutory requirements (WIC 5345-5349.5):

- Community-based, mobile, multidisciplinary, highly trained mental health teams that use high staff-to-client ratios of no more than 10 clients per team member
- Service delivery that includes outreach to families, mental health treatment, access to medications, substance abuse services, supportive housing, vocational rehabilitation, veterans' services
 - Age and gender appropriate; cultural and linguistically competent
 - Provision for special needs of homelessness, physical disabilities, transition age youth, older adults, peer, self-help, parenting and family support
 - Employ principles of client-directed, psychosocial rehabilitation, and recovery



Review of Treatment Model (2)

- Each client will have a personal services coordinator who is responsible for assessing and providing or assuring needed services according to an agreed upon personal services plan
- With client consent will consult with family and other significant persons and designated conservator
- Must include appropriate services to persons suffering from an untreated severe mental illness for less than a year, and are at risk for being homeless
- Provide a yearly report that includes demographic, outcome and evaluation of program effectiveness information

Treatment Goals

- Live in most independent, least restrictive housing feasible
- Engage in the highest level of work or productive activity
- Create and maintain a natural support system
- Access appropriate education/training
- Obtain an adequate income
- Self-manage illness, life skills and decision-making
- Access physical health care and maintain best possible health
- Reduce or eliminate antisocial or criminal behavior
- Reduce or eliminate distress from mental illness symptoms
- Have freedom from dangerous addictive substances

Treatment Model Issues

- What is county operated and what is contract provided?
- What is provided by the Assertive Community Treatment Team, and what is coordinated with existing community resources?
- Can potential consumers apply directly to the ACT team for services, and receive services while eligibility is being determined?
- How, when and who will determine whether lower levels of care are appropriate, and how will this be coordinated and incentivized?

Training, Marketing, Evaluation Oversight Issues

- Who will have the lead for the following, and what are potential issues for workgroup input for:
 - Training of treatment staff, court/law enforcement systems, line and senior management, oversight bodies, Board of Supervisors
 - Marketing and communication of program design, progress, issues, outcomes and evaluation
 - Program evaluation design
 - Oversight design

Suggested Agenda Topics for Next Week's Workgroup Meeting

- Consumer perspective
- Family member perspective
- Psychiatric emergency response
- County and contract treatment providers
- Court, legal proceeding participants
- Law enforcement

AOT Workgroup Notes, April 23, 2015

Welcome: Cynthia welcomed everybody and gave a brief statement of the purpose of the workgroup meeting.

David Seidner and Warren Hayes utilized a PowerPoint presentation to provide information on Assisted Outpatient Treatment and posed potential issues for discussion (see attached). Workgroup participants added the following questions:

AGENDA ITEM 3: REVIEW SEP 2014 AOT WORKGROUP REPORT

Questions raised:

1. Who can refer a homeless person for AOT?
Comment: The code states what types of persons can refer a homeless person to AOT; any of these persons coming in contact with a homeless person would be qualified to refer them.
2. Does a non-citizen who is in the country without a green card fall under this law?
3. Would an emancipated minor fall under this law?
4. How would you define "with whom the person who is the subject of the petition resides" for someone who is living in a board-and-care, a sober living environment, or a shelter?
5. How would the law apply in the setting of jail mental health? Would sheriff's officers working at the jail fall under the category of a peace officer assigned to the person?
Comment: This needs further clarification. A treating psychiatrist would most likely qualify as a treating mental health provider; however, a clinician may or may not.
6. For a homeless person, can their parent, spouse, or sibling refer them even if they do not live with them? What if the homeless person is estranged from their family?
Comment: There is no requirement that a parent, spouse, or sibling must reside with the homeless person to be eligible to report. The issue of estrangement needs further clarification.
7. What if a friend wanted a person referred, but the person has no law enforcement, health care, or family contacts?
Comment: A concerned friend could contact law enforcement for a 5150 evaluation in the case of a psychiatric crisis. This issue needs further clarification.
8. Would a mentor/mentee to someone who is incarcerated or out of custody be eligible to refer? What about a mentor/mentee under the guidelines of AB 109, through the Sheriff's Department, Men or Women of Purpose, etc.?
9. Would a person who does not want any contact with their family and whose family has referred them have the right to refuse?

AGENDA ITEM 4: REVIEW FEBRUARY 2015 BOARD OF SUPERVISORS RESOLUTION

Questions raised:

1. What is the difference in treatment between voluntary and involuntary participants?
Comment: The law states that they must be treated equally. The only difference is how they are engaged and the process to get them into AOT. They are being distinguished in order to evaluate the success of each group.
2. Are housing subsidies or housing provided as part of the program?
Comment: This is included in the law.

AGENDA ITEM 5: REVIEW FEBRUARY 2015 COMMUNITY FORUM INPUT

Questions raised:

1. Are these comments in this section applicable or enforceable under Laura's Law, or were they just comments made by the public?
Comment: They were comments made by people in a meeting that was held for public comment.

AGENDA ITEM 6: REVIEW LEGAL WORKFLOW:

Questions raised:

1. Regarding the investigator who makes the decision, will this decision be subject to some kind of review by their supervisor or someone else?
Comment: This will need to be clarified, but in general, decisions on similar things have typically been signed off by the supervisor.
2. With a statement that the program will serve up to 75 participants per year, what happens when that limit is reached well ahead of year end? Is there an alternative option?
3. How does dismissal for noncompliance work in the case of someone who was not a voluntary participant?
Comment: The decision would be made by the treating provider(s) that the treatment is not effective, which could be because of a non-psychiatric issue. This issue needs further clarification.
4. What about someone who is compliant, but the treatment is not working?
5. Will out-of-county options be available for treatment, or will we be limited to options that are within the county?

AGENDA ITEM 7: REVIEW TREATMENT MODEL FROM WIC 5348

Questions raised:

1. What would a sample treatment program look like?

AGENDA ITEM 8: DEVELOP DISCUSSION TOPICS FOR NEXT WORKGROUP MEETING

Workgroup participants provided the following input for assistance in developing agenda topics for discussion at next week's meeting.

Consumer Perspective Issues

1. How do we watch that we do not re-traumatize a person who has been traumatized through the court process? Will there be an alternative route for them? Would they be able to have an advocate or support person during the process? Could there be a different type of setting for them?
2. Will there be parties helping the consumer understand their legal options outside of just their representation? Are there other allies that can be part of that discussion process?
3. Does the consumer have to attend the court hearing if they do not want to? Can they agree with their public defender that the public defender can appear for them, or can the patient sign a waiver similar to the Gallinot hearing process?
4. How can we ensure that this remains a compassionate process?
5. How can we ensure that the process is sensitive to ethnic and cultural diversity and the consumer's lived experience?
6. What is the process for emancipated minors?

Family Member Perspective

1. Can we obtain and use San Francisco's model as an example in formulating our plan?
2. How much information will the investigator be allowed to give to the requesting party when the consumer does not qualify for AOT in order to avoid negative reactions by the requesting party if they feel the decision is wrong?
3. Will there be any support provided for family members who find it traumatic to request a referral on their relative?
4. Will there be reasonable outreach parameters defined before referring a person involuntarily?
5. Will there be a family liaison? Will there be a peer representative? If so, what will be the qualifications for them?

Psychiatric Emergency Response

1. Will there be an outreach team such as a mobile care team or mobile crisis team separate from the treating team? If so, who would be on the mobile crisis team?
2. What are the qualifications of the professional who will be assessing the consumers?

3. Would an outreach team be separate from the treating team, or would it become the provider?
4. There are time frames listed in the course of the referral process. Does the entire time frame have to elapse before proceeding to the next step?
5. At what point would a care team make a crisis 5150 recommendation to the referred individual?

County and Contract Treatment Providers

1. Does your delivery system include substance abuse community-based programs as well as programs like Nevin house?
2. If we cannot provide needed treatment to the consumer, will the consumer be considered a failure?
3. Is the 24/7 program going to have 24/7 face-to-face availability? Would telephone contact suffice?
4. What are the actual evidence-based tools we are going to use? What are the services to be provided, including the evidence-based practices to be incorporated in the treatment model? Will it include CBT, DBT, drug and alcohol, codependent, trauma, and other similar services?
5. Will the program include training on budgeting, WRAP, IDDT, CBT-D?
6. Could the program include training the consumer on how to respond to law enforcement?
7. Could the housing options include sober living environments?
8. What functions are going to be performed by County people, and what functions are going to be performed by contract providers? How will that be decided?

Court, Legal Proceeding Participants

1. What are the expectations around training of court staff, including bailiffs, and is there some trauma-informed training already available that could be included in the program?
2. Will there be alternatives to a settlement conference in a court setting between attorneys, such as mediation team decision making or other alternatives?
3. In the settlement agreement process, can other parties be a part of that process, such as a family liaison or a peer representative? How could it be made the most user-friendly?
4. Could the law enforcement response be discussed at a meeting such as a Chiefs of Police meeting in order to coordinate policies to help develop a more consistent response? Could law enforcement personnel other than Sheriff's Department personnel be included in the planning process?

5. What requirements will there be to train law enforcement?
6. What requirements will there be of law enforcement during this process, such as serving papers? What funding will be available to law enforcement to cover any additional expenses they may incur?
7. Could the role of patient rights be expanded, not in an adversarial sense but in an advocacy sense?
8. Will law enforcement receive training in ethnic-specific mental health concerns?
9. Could courtroom staff be required to take something like CIT training?
10. Could the Veterans Administration in Martinez be invited to participate, since there may be some interaction or overlap?

ADDITIONAL PUBLIC COMMENTS

1. Can workgroup facilitators make sure that workgroup members have links to online videos of other courts such as San Antonio or those in New York with Kendra's Law?
2. Is the housing subsidy included as part of Laura's Law a short-term subsidy, or is it permanent? What should the consumer's expectation be of that subsidy after they leave the court?
3. What leverage does the court have if, at the end of the flowchart, the individual declines AOT? It looks like the flowchart points it back to 5150, which is even available throughout the process. So what is the court leverage if someone continues to decline, beyond just the result that we already have, which is 5150? What do you do next?
4. Theoretically we could have 112 hearings of possible habeas corpus writs if there is a hearing every 60 days for an individual to prove that they are still meeting the criteria. How will staff be provided to manage that workload?
5. Will housing subsidies continue as the consumer regresses to a lower level of care? How are we going to find the large amount of housing stock needed for housing programs?
6. After a consumer has completed the entire Laura's Law process, how soon could they be re-referred back into services, and how many times would this be allowed to happen?

AOT Workgroup Summary, April 30, 2015

Warren provided rules of engagement for this week's meeting, contrasting the purpose and rules of engagement of this meeting with those of last week's meeting. He stated that a draft program design will be developed after this meeting and forwarded to all workgroup members as soon as it was completed, and each member should review it carefully and provide any input they feel is appropriate. On May 19, the workgroup will meet again to walk through the program design draft and provide feedback. He emphasized that it was important to get feedback from those in all the disciplines affected by the program, not just the people involved in treatment.

Workgroup participants provided the following comments and questions:

Issue #1 – Preparing for AOT:

1. It seems it would be valuable to have a publically designated clearinghouse named in materials that go out to the police that if they have feedback, send it to this entity, and they would be responsible for summarizing feedback so the feedback could go back to the supervisors the next time they look at the program.
 - Regarding the above issue of a designated clearinghouse for feedback, would we want to consider having the care team involved in educating law enforcement, patient rights, etc.?
2. What would the treatment plan look like, and who is going to be compiling the treatment plan? This is the basis of the court order and a settlement.
 - We are already being proactive with forensic multidisciplinary teams for the three agencies that are representing the county: Concord, Pittsburg, and Richmond. They are all coming to give training to the staff on this program, what will be available to them, and the full process and what is involved with that. This process will continue throughout.
3. From a clinician's point of view, it sounds like law enforcement is comfortable in taking the lead and setting that up for your community and having us participate. Is that correct?
 - As far as the Sheriff's Office is concerned (but not the other 24 agencies in the county), we are divided by station houses, and each of our station house representatives will be attending monthly meetings facilitated by the forensic multidisciplinary teams and their respective agencies, and they are going to be getting monthly updates as to how the program is going, those who are participating in the program. It will be an avenue for helpful to push the referrals forward and then to get feedback on those referrals. We are going to facilitate training in-house by either having you come in yourselves or providing us with educational/training information on mental health cases. We very comfortable being the avenue to disseminate

information within our organization, but we rely upon your expertise to come in and give us a good understanding of the program itself, things that are and aren't working, and how we can help make it more successful overall.

4. What are the thoughts of those in the courts – the Public Defender and those in the courts?
 - The first question in terms of the court structure is, to whom are the referrals made? If you have individuals who are defined as potential referring persons – a family member, a cohabitant – who are they supposed to call? Then when that call is made, somehow it has to get from that round to somebody who is going to do the evaluation and decide if this person is someone who should be referred and if they meet the qualifications. Then there will be a decision made about if it goes to County Counsel to file a petition. So County Counsel is the starting point for the court process, and County Counsel has to file a petition. That is the point where the Public Defender's office gets involved, because when a petition is filed is when there has been a person identified who needs an attorney appointed to represent that person in the process. So from our perspective, we do not get involved until someone has been identified who is going to be referred for AOT, and then we get involved.
5. It sounds like the court system is keenly interested in how this process will play out so and how you are involved. What about in terms of broader topics, like more education around mental health?
 - The courts don't need that.
 - The Public Defender's office expects to have various members calling us; potentially the person the petition has been filed against as well as parents or community-based organizations, and we need to understand how we manage that as well.
6. What would be helpful for the Public Defender's Office to have prior to the launch of the program in order to deal with that?
 - We need something like a Frequently Asked Questions document; a very clear, plain-language flowchart and information about this program. We will have people wanting to know about this program, how one ends up in court, and what happens after they stand in front of the judge. Those are questions we will have to train our staff on. You will need to count on us to give you some plain language and information and about what happens in the court process, who to call, what window do I go to, and I think as far as training our staff, we would be looking for the same kind of information on the rest of the process from you.
 - Also, Public Defenders will also have misdemeanor clients either out of custody or potentially in MDF or West County who would qualify for AOT and should be referred for AOT, but they are not yet in any mental health avenue. Maybe they

would agree to AOT voluntarily and not end up in the court process through AOT. I would be interested in what the Sheriff's office is thinking about when they might have someone at West County or MDF who would qualify for AOT; how that referral process is going to happen and what that will look like in terms of a treatment plan if the person is currently in custody pending some sort of adjudication on their misdemeanor.

7. It would also be helpful to know when you get that call and the person gets the paperwork they have never seen before and are concerned and stressed, where the court should guide those people and what resources they should contact? I would hate to just say, "You need a public defender." We need to know where you want the Court to guide those people.
 - In terms of referral, in the San Francisco model, the care team has a very key part to play in most of this up-front process. Their metamessage is to try to make it as voluntary as possible for as long as possible – at least 30 days per the statute – and then there are other processes.
 - At some point, there will be information that would go to the Patient's Rights Advocate Program and probably others. It would be helpful to be clear with the advocates about what role they have to play other than advising the client about what the program is going to look like. Their interaction could be helpful in explaining someone's basic rights. On the other hand, I would not want to see an adversarial type of position taken; I think that would cause confusion.
 - Regarding the voluntary referral service, is 211 or the Crisis Center going to be involved? They are already front-line establishments, or is there a separate number to call?
 - Does anyone in the Probation Department or Sheriff's Department know about the AB 109 mentorship program and if they will be involved?
 - Who is going to be involved from Homeless Services? Will there be a homeless persons' team, or will it be specifically focused on shelters?
 - This item has already been brought up for consideration.
8. Regarding jail settings, there is already mental health staff and nursing staff in jail facilities, and deputies will be able to refer people from a jail setting as well. It will be an educational process with those in custody that this program is available, and that will be something we will have to work with Mental Health on, whether that is a pamphlet or something that we can distribute to the inmates that makes it available to them in a custody setting. This is what we are best able to do to facilitate this, because we have all the staff in place already, and the deputies are regularly referring individuals they think may need mental health assistance in the jails.

9. As an RN, if I had a patient who was mentally ill under my care, I would never allow a reporter to talk to a psychotic mentally ill person, as occurred this weekend to someone in jail. This is unacceptable to me, and it very much upset me. I would have protected that patient. This is my concern.
10. We have a rare opportunity in that we have two Bay Area counties who are also in the process of developing this program. Perhaps our people should communicate with their people to see what they are developing, as it is likely there would be some synergy, and as they are smaller counties and we have greater resources, they might need our help.
11. San Francisco has a very rich history of many specialty-type courts and is drawing on it to develop their program. That could be another avenue to tap into.

Issue #2 - Initial Response:

1. How are you going to approach someone who you think needs the AOT program and tell them you think they need AOT if they are not to the point of the court process?
2. What will care provision to the consumer look like, and who will do it? As an example, in San Francisco there is a city employee-chosen care team who has the lead responsibility to reach out to referred persons. They will be allowed at least up to one month to reach out to this person. They will be looking to see if there is further substantial deterioration toward a 5150, but they will be consistently reaching out to this person in as compassionate a manner as possible.
 - A point to keep in mind is that Nevada, San Francisco, Contra Costa, San Diego, and Orange Counties are all starting to design their program. They adapt their design to their resources, teams, and cultures are. CCC is unique. It is good to see what other counties are planning or have done, but we are not locked into their design. We would like discussion about the model or design on the front end.
3. The Public Defender's office is completely dedicated to making this a collaborative process and encouraging this process to be enacted in as voluntary a manner as we possibly can. We are interested in any kind of model that takes this out of a courtroom setting, if that is possible, and to have it non-adversarial. All of these things are important to us, and when we are talking about mental health and especially a civil mental health proceeding, which this is, those are all good things. We are advocates for the patient who is referred, but that does not mean that we are going to necessarily be taking an adversarial position. At some point, though, if the person we are representing is advocating on their behalf for a position that is contrary to what County Counsel or others believe, we are going to advocate for that client and their position. I do not think that is inconsistent with trying to have a collaborative, voluntary, best interest of the client type of approach. We are all in favor of that, but having said that, we still need to iron out the nuts and bolts, and I don't know that this working group is going to do the ones to design the forms and the court process and when the calendar will be, but I don't

know if questions like safety in a non-controlled setting refer to the issue that came up that there is a bailiff in every courtroom, and when you have a judge, you have to have a bailiff there.

- We are talking about out in the field: If there is an investigation that a mental health clinician and/or care team is responsible for doing, what are the issues around when they say it is unsafe, and what do they do about it?
4. In the San Francisco model, the care team goes out along with a clinician to be involved in making some determinations, although the clinician has the ultimate final say. In talking with EMS personnel, in our county they usually have an ambulance come out if necessary outside of a hospital setting. Is that something that County Mental Health would want to consider to keep going as far as safety issues in a non-controlled setting? I saw something in the agenda for last week about whether we want to have sheriffs come out if there is a safety issue to make the determination in the most non-confining condition possible.
 5. My idea is some sort of friendly mobile response. If you send law enforcement or an ambulance, it could be embarrassing to the individual. Then you could include peer support personnel, a clinician, maybe a member of Forensics, because they have the law enforcement background in plain clothes, and then maybe a family member that the individual trusts in an intervention type of setting.
 6. I would like to follow through on what was stated earlier about the 211 crisis line. I think many lay people, as opposed to clergy, and most of the public would probably call there. The likelihood is that they would call there during a 24-hour time zone period – it might be midnight or whenever – to talk to a person immediately about these issues. I am hoping that they would be kept very current on the process and procedure.
 7. I would also like to commend both the county hospital and the Sheriff's Office personnel who work at the county hospital. Ever since last summer, the Sheriff's Department has been putting on classes in 4C to introduce law enforcement as a friendly organization, because many people are admitted to the hospital in 4C whose only contact with law enforcement has been adversarial, and that is all they have known. We have found that this helps to break the ice in setting a more friendly tone and atmosphere of law enforcement in the county.
 8. If the person is in the hospital, one first step may be to have a social worker sit down with the patient to tell them about AOT in the setting they are in. If they are not in the hospital and are with their family, someone could visit their home. I think having a less hostile environment is the best way; better than having someone from law enforcement or strangers there. If the person is homeless, there are people and organizations who reach out to the homeless, and perhaps we could use those people with the people who are reaching out to tell them about AOT for the initial first contact.

9. As a member of SPIRIT, one of the things I remember specifically is that we don't suggest treatment to anyone. We talk to them as a human being and try to bring the desire to have resolve from out of them in the hope that they would volunteer to be involved in something. I would stress that if not SPIRIT or a CSW, there should be someone trained as a peer advocate, and I like the whole forensics concept, as in somebody with some law background who does not appear threatening.
10. I would like to suggest having a CIT-trained law enforcement member on the treatment team for the AOT. For some years and in spite of many negative incidents, this county has had many successful incidents with officers with mental illness training who have done marvelous jobs with getting people over to the hospital. In fact, we have a policy and procedure at BHC that we do not have to 5150 people very often, but we do have people who request to go to the hospital or who do need to go over to be evaluated. We have an arrangement with our officer who is a member of the treatment team, and everybody knows him. We work with the officers and have never once had to have EMTs arrive for someone. The officer is able to escort the person without handcuffs and in very calm ways. The officer stays with them as much as he can. It has been highly successful and really marvelous. It is the clinical team who works with the individual to talk about what will happen at the hospital or Psych Emergency and works with the officer. They become very trusted people. It can work, and it has worked for many years, so it ought to be something to be considered.
- In San Francisco, a family liaison member and a consumer peer counselor are part of the initial outreach care team.
11. As a family member with experience working with a couple of officers with the Concord Police Department and with the Sheriff's Department in Contra Costa and San Mateo Counties, that training made a difference in more of a positive resolution during one crisis that I had with a family member, and I think it really helps. I especially like the positive approach mentioned regarding a peer counselor. I hate to bring anything negative into this, but one thing I would not want to see and would want people to really make sure to watch out for is someone who takes a more radical approach to mental health – to me it's a political approach, and it's the mind-freedom approach – and I have seen that do damage. I do want people to be aware that this kind of thinking is out there with the San Francisco Mental Health Association.
12. It seems that when a report comes in to Mental Health to whoever the person is there who is going to make the decision, the first thing they can evaluate is, is this reasonable? If somebody calls in and says, "I want you to lock my neighbor up. His tree is driving me crazy," you are not going to send a three-person team out. If they get a report in that seems reasonably worth following up, it seems to me that they are going to have these three-person teams on call, and they should call one and say, "Go talk to this person." There are several advantages to that. You get three sets of eyes on the person. You get a team that is sensitive, and so they can work with making sure that is not any more traumatic than necessary. Also, there is safety in numbers; you have three people out there and three perspectives that can report back to whoever is the mental health

“quarterback” with what they have seen and help the person decide if this is a case we want to assign for full treatment or a case to pass up.

- We are still working on the idea of how the identified requestor will interact with the system. If you envision potentially a hotline and whoever is that first contact, what the Welfare and Institutions Code says is that the person making first contact has discretion to deploy or not deploy. I think the question is whether there is some type of assessment at the front end of receiving it. The second part was responding back to do the outreach or investigation, which is very different from crisis responding.
- When the police come in my neighborhood, it means you have done something wrong. I would never want to be placed in a police car. Now I don't open my door any more to the police. To me, a policeman coming to my house is not a good thing.
- So whatever party receives the referral, we will have to go out and investigate. I am unsure if we can make that determination just off of receiving that referral.
- In San Francisco, the three-person care team goes out based on referrals to contact the individual. We are talking about multiple hospitalizations of a person within the last year, not necessarily three years, but within the last year. That is a type of baseline outlier before there are any kinds of referrals made to talk with the referred individual for assessment.

13. Under existing practice, does Mental Health want to call an ambulance to come out to assist as a backup when they make the evaluation? That seems to be the current practice of the county. Do they want to continue that practice?

- Law enforcement agencies have a routine thing they call a civil standby, where if they can see that this is potentially a dangerous situation, they will send someone out to be there to keep everybody focused on behaving civilly, because it is clear what would happen otherwise. I think in a situation like that, there is no reason this team would be created differently than anybody else, and I suspect in that situation, the officer, if they are in a unit, does not have to come up and be the one knocking on the door as long as the team knows they are available in 10 seconds. This way they can avoid that trauma but still have the protection in a case where the report is a scary report and the team needs reassurance for that.
- I can respond as to how Case Management responds in a community crisis. In the event that a clinic case manager or mental health clinical specialist is providing services in the field, if we determine that the person meets criteria for 5150, the clinician will call the local dispatch; e.g., the local agency. We want to keep the consumer safe and comfortable as best we can. We keep a safe distance as well. Then essentially we will start the 5150 petition. We will ask law enforcement to check the scene, make sure the scene is safe and the person is remaining safe and comfortable, and then law enforcement will call for the ambulance. Then the individual will be transported from that location to Psychiatric Emergency.

14. From past experience, any time you are going out to see someone on the streets, you don't go and walk up to a person the same day. You investigate. You get to know that person. I can see someone walking up to a person I know on the streets who would beat them up. You have to give a homeless person a chance to know you. You bring them a treat, because they are usually hungry. It is all about how you treat them and how you approach them.
15. To clarify about immediate outreach and ambulances, they apply to 5150 criteria. AOT is not 5150 criteria. First off, there will be an investigation to see if the individual meets criteria for AOT outreach. There will be a lot of phone calls and referrals that do not meet criteria to pursue AOT. Once AOT has been determined to be appropriate, that outreach will be slower, more like what Duane described. Hopefully it will be a more humane and slower approach. If someone meets 5150 criteria, that is a different discussion altogether.
- Regarding the safety issue, if you feel there is imminent danger such as violence, I think those instances would be when you do the investigation first. If you have investigated and feel that is the case, then you would send somebody from law enforcement and have them stand on the sidelines so they can step in in case something does happen.
16. In established CIT Training and other types of training, it is always recommended that if there is family or friends involved who have called to the attention of the AOT Team that someone might need to be evaluated for AOT, there would be a significant discussion with them about the individual's status, where they are, and how they are behaving. There would be a long discussion about safety issues, what the individual is doing, how they are behaving, how they might act when we come up to the house. There would be significant information exchanged between the team members and any family or friends. Obvious there aren't family and friends involved in every case, but it is very important that you get as much information as possible that can be passed on to the team as well as to law enforcement so there can be plans made. If somebody is barricaded in a bedroom, that will be a different approach. One of the procedures is about how to assess prior to going out what is happening. That is part of the investigation and review of the individual's history, and it is part of talking to family and friends.
17. Some of these people will be homeless. There are people in cities who know some of these people who are homeless, and bringing those people along for the initial contact would help a lot. For example, I know some homeless people in my neighborhood who I am in contact with, and to get some people who know that homeless person out there, it makes it a lot easier than three people who are strangers going out and talking to that person.
- This speaks to how you define the care team.

18. As I have it, the team is basically a CSW or SPIRIT, someone from Forensics, and a family member. In a perfect world, the family members are the ones who are going to give the personal review besides the paperwork trail that we have. For those who don't necessarily have family, who would replace the family member in that case?
19. I hope that in the event that there is an emergency, the care team would have a quick way to get help. Lately, if you try dialing 911, there is a wait, so somehow they need to be able to go through a back door to get some help.

Issue #3 - Consumer Experience:

1. If law enforcement had to go out and greet this individual who has been determined to need AOT, I believe it should be in a plain car and in plain clothes. I agree that if the police show up at your house, the neighbors see that, and it can be embarrassing to the individual and not necessarily just individual. Then the neighbors will ask why someone got picked up in a police car, or why were the police over at their house.
 - I think this comment speaks to the issue of how to mitigate the traumatic effects during the process.
2. Could we get information as to how teens and adolescents in this situation are currently handled, since Laura's Law does not apply to them? They still go through an experience that is similar, and some of these individuals may have already gone through it by the time they reach the age where Laura's Law does apply and would therefore have that background experience in their life. I think it would help us to know what adolescent treatment is in Contra Costa County.
 - This varies across the county. It is handled by local police departments. Most of the time, those cases are children who are 5150'd from a school site during the day. Frequently the police are called and the youngster is detained. Unfortunately, more often than not they are handcuffed and escorted off campus. We are working to change that by having our mobile response team available to go out to school districts to do field-based assessments on those kids they think need to be 5150'd. We are piloting it in the far East County in the Liberty Union High School District. The next step is to move it to the Mt. Diablo district. We have recently hired a PES crisis liaison who is mobile, and if a youngster needs to be 5150'd out in the field, she is able to go out and meet the mobile response team and execute the 5150, call the ambulance, and have the youngster taken in. If there is a threat of violence or harm to self, it is immediate, then, of course, we end up having to call the police, but we are trying to handle it in a little different way going forward.
 - What is the composition of that adolescent mobile team?
 - There is a friend or family partner and a clinician involved in it. My family partners are the same as a Community Support Worker or a peer worker. Often they will go

out in threes with two Family Partners. It depends on the time of day and the volume we have. We are currently expanding mobile response by actually putting them out in East County, because the driving time to get to East County from Central County is so difficult that it would often take over an hour to get there, which is not exactly a mobile response.

3. Are we talking about the healing process after dealing with the confrontation of the event?
 - It is a little broader. We are looking at throughout the process, because the individual concerned may be involved in court proceedings not just on the front end.
 - I see it summed as in two words: education and compassion. On every single level, it is educating the individual with what is required from the legal aspect to what is required from the voluntary aspect, and then having a lot of patience and listening to what the individual client is saying.
4. Regarding how we mitigate the traumatic effects, in San Francisco, their care team follows the outreach of this person all the way through up to the judicial order, so the composition of that team is very important, and it is designed to put any front-end interaction with law enforcement or the less process to the back end as much as possible and hopefully avoid it if the care team is able to get voluntary agreement to obtain services and treatment.
 - This speaks to making sure the response is community- and culturally-responsible to the individual, which you want to make sure you build into the team. Is there a need for anything beyond the care team, who in San Francisco is the point in following the person through the process, to counterbalance any issues around the person's getting a culturally and linguistically appropriate response and making sure that the person's rights are translated in a manner they can understand, so they can then make the best possible informed choices.
5. I entered the mental health system because I was sexually assaulted. What helped me the most through the legal process was having an advocate, a counselor, who was someone who had experienced the same thing. I did not use her that much, but for some things I went it, it felt good just having her by my side. I would like to see that with the consumer going through the court process.
 - Do you think in terms of program design, it should be somebody who is not part of the paid staff?
 - It was nice for me that she was not a legal person, not a judge. I felt that everyone was staring at me, but I knew that this advocate was there and I could hold her hand. It comforted me that she was not objectively involved and was just there for support. It would be nice to have someone there for them who is not judging them or thinking anything of them.

6. I volunteer at a mentoring program going on in Contra Costa County through AB 109. I also think about programs like CASA [Court-Appointed Special Advocates]. It sounds like the same approach. Culturally it would be a good thing to have someone they can identify with, and I think it would help the process go smoother. One time when I went to a 5150 meeting, the patient threw the knife out in the middle of the floor, and no one knew what to do. Because I was able to talk to him and understand, that made me culturally okay with him. From a human perspective, they need somebody that they can trust when law enforcement or someone like that is coming to help.

- Do you think they should be paid or unpaid? If they are paid by the budget for implementing this, they become part of that system.
- There is a paid model in juvenile dependency. The Parent Partners have gone through the system and become partners for the parents, while the CASAs are there for the children. That is probably a better model for this process than a CASA model or a rape crisis advocate.
- Initially there should be both. There already would be a paid model. Those would be individuals from different organizations that are involved. As an advocate myself, I would want to promote that individual volunteers should be developed at some point to build a general group. Based on the number of persons expected, though, I don't know what the general pool of individual people to pick from would be as far as the cultural aspect.
- Are you saying we should pay attention to the capacity to provide that? If you pay for it, you can be assured that it is there. If you don't pay for it and want an independent, non-bought voice who is truly there only for the individual, then there is a capacity issue.
- I think we should have both.
- I was thinking of a wraparound model that they use with children, so that a person who is close to the individual would be the nonpaid individual. The clinician and peer support people would be paid. Maybe there should be a family member or a friend, because those who are referring these people apparently care about them and know who they are close to, so maybe we could see about how to get these people involved.
- San Francisco, who is looking at a population of 100, plans for one care team, and then they are looking to hire paid positions through a community-based organization for situations like these.
- Maybe a stipend for the volunteer along with a person or CBO, so that person would actually become trained to step into a position when they are better informed.

7. I would like to address issues of trauma and safety in the courtroom. I have clients who have been going to court for a very long time, and they are still quite frightened of court, even though we have done a lot of things to make court safe. We applaud, we give out rewards, etc. There are a lot of things that can be done, and I know the Public Defender works with us to do that. We do not have a District Attorney in the court, and that helps a lot, so there is not an adversarial setting, generally speaking. You need a judge who will engage the individual. I think more than anything, before that individual goes into the courtroom setting, there has to be a very thorough explanation and maybe even a type of checklist of what is going to happen and what is not going to happen in court, that this is not about trying to 5150 the person but is about trying to get services as appropriate, or whatever the language that is going to be adopted.

I would love to see the judge not on the dais but actually sitting down in the courtroom. I recognize they have to have a bailiff, but I think that there are ways to make it less intimidating. That includes the judge's not wearing a robe. That is something that can be proposed. That is done in other places, and it is done in a circle, where it feels less threatening.

Being able to have the client have a consumer advocate on one side and a treatment person on the other is sometimes very helpful. I think that by definition, having to go to the court and appear is always a problem, but I think the most important thing is saying, "This is what is going to happen in court. We are going to walk you through what is going to happen and what we would like to have happen. And what this is really about is an intervention to try to get you to participate in services." I find that even with clients who know they are struggling with stability will say they don't want medication and we might want to medicate them or send them to the hospital, that they are afraid that they will be 5150'd. We start with the approach, "This is not our approach; a 5150 is an absolute last resort for us. What we would really like to do is the following: We would like to make you feel safe. We would really like to help you get some services. We would really like to find out what you want and what you need, what would help you out. What we are not looking at is 5150. What we might do, if you are willing, is to possibly see if we can get you an urgent care appointment to see a psychiatrist and have your meds looked at. This is all about what we would really like to see happen to help you navigate in the community right now and not about what could happen if you go to the hospital." I think you should take 5150 and hospitalization off of the table so that going to court can be about services.

Issue #4 - Family Member Experience:

1. With this year's SPIRIT class, we were supposed to push to have family members of mental health clients involved, but it depends on the compassion, education, and tolerance the family member has and how they are dealing with the situation, assuming it was all positive.

2. In the San Francisco model, the care team is supposed to work to get the person's consent; however, they do look at all of the records available about the person's not accessing services. Also, there is a family liaison member who needs to be able to communicate something to the family. From the family perspective and my own personal experience, while I know that because of HIPAA laws we cannot get too much information, I feel that family members should get a confirmation of receipt of what information they have provided even if the referred person has not given consent to share information with them.
3. In my case, I have no family member in the area. What is the process for a person who may need AOT who does not have a family member available, who has no family members accessible, or who is estranged from their family?
 - It might be helpful to develop a form where the person who state who and what types of contacts they would agree to give permission for information to be passed along to.
4. We are talking about all kinds of people: support systems, friends, neighbors, fellow SPIRIT students. There are a significant number of people in this county who have done a WRAP [Wellness Recovery Action Plan] plan. I would like to recommend is that we find out as part of the investigation team is if they have a WRAP plan. If they do, they have designated people they would like to have speak for them and, just as importantly, they may have designated people they absolutely do not want to represent them or speak for them. I think that is important, but even so, I would think the AOT Team or whoever is investigating and researching up front ought to talk to the people that the referred person does not want them to talk to. They cannot share information with those people, but those people could share information, and some of what they might have to say could be valuable in assessing the big picture. That might not be something that everybody wants to hear, but I believe that besides getting family support, neighbors, etc., it is important to get a big picture at the beginning before doing the actual assessment. The families, the support people, and other people who are concerned have to feel heard and have to get a response. Whether or not they get any information or are involved any further than that, they have to feel heard.
 - I disagree with getting information from the family. My husband has given out information that has caused me to be on meds I should not have been on. The consumer needs to be carefully assessed, and their concerns need to be heard.
 - Regarding the medication issue, the patient always has the right to an informed consent unless they have been determined to be without capacity by a hearing officer. I would hope that whenever medication is prescribed, the consumer receives the risks and benefits of the medications and that they be allowed to sign that they have received this information and consent to take it. Then if there are side effects, they should be able to talk with the doctor and try to find alternatives. Also, regarding HIPAA laws, some parts of the county won't accept forms from another part of the county, so I would like to see a form for the AOT Team that everyone would recognize.

5. Regarding what information is shared, which direction are we talking about? Generally it seems to be that the team getting information needs to get information from whatever source they can and evaluate it critically. The problem is not that we might get misinformation reported because somebody has a grudge or whatever. The problem is that the person reporting the problem is not critically evaluated by the response team and whoever is making the decision. In my county, I am sure that will be critically evaluated, because they understand that you hear all sorts of off-the-wall things about all sorts of people. If we were going to take everything at face value, that would be horrible. In terms of the information being a two-way street and what information can be shared with family members, that seems to be an interesting legal question. Maybe County Counsel has already figured out to what extent this is governed by HIPAA rules, because it's treatment-related, and to what extent is it an investigation regarding a court proceeding, in which case investigations regarding court proceedings are not covered by HIPAA. The more information that can be shared with the family members overall in a healthy situation, the better the feedback is going to be and the more cooperation we will have. We want everybody working together as much as possible, but there are different possible scenarios. We could have a subject of the proceeding who doesn't want the parents involved for completely irrational reasons, and the parents are very helpful and supportive and have been a key component. On the other hand, the subject of the proceeding could be right: the parents could be the people who believed that mental illness is a punishment from God and had to be beaten out of them. In that case, sharing information with them is not going to be therapeutically helpful. It seems to me that whoever is running the program needs to have some discretion to decide what that is going to be, subject to County Counsel telling them what they are allowed and not allowed to say once they have figured out what their privileges are, and whether it is an emergency or not.

- First, once it gets to the court proceeding, I believe that any court proceedings would be closed. I believe there is case law in the last three years that states that all of those court proceedings would be closed. Anything under Code 5000 is closed, and I believe this falls under Code 5328 of the Welfare and Institutions Code, as it is a court proceeding.
- Could the investigators give feedback to someone who says, "I saw this"?
- It depends on the feedback. I think that once it goes to court, it is a closed proceeding. The parents and the supporters are just like in a conservatorship.
- I disagree with County Counsel. That is not my understanding of how the collaborative process of AOT court works. If that is the intent of County Counsel, we have a real issue. San Francisco has a rich experience with other specialty courts, and they try to be as collaborative as possible. If the courtroom proceeding is automatically closed, it is very problematic. If the public defender says that is what they want, then you do have to honor it. But to just start off with that premise, it

practically sabotages the purpose of a collaborative AOT court process, because families automatically cannot be present to hear the evidence that is being presented.

- So are you advocating that family members, whether or not the client gives written permission, should be allowed in to hear the evidence?
 - If the person does not want them there, then obviously they can't be. But the whole purpose of AOT Court is not traditional LPS [conservatorship] court, it is not a more adversarial type of mental health court proceeding. I am afraid that if County Counsel goes down that road, this is exactly what could be happening, and it would sabotage the process of AOT.
 - (Question to County Counsel) If a subject of a petition gives written permission for family members to be in court, is that allowed?
 - (Response from County Counsel) Absolutely.
- I have not discussed this with other counties, so I can't say, but from the outset I feel that recent case law has clarified that proceedings under the W&I Code 5000 are closed proceedings. Before that case came out, the issue of confidentiality was handled on a case-by-case basis in each county. I will talk with the public defender and other counties and see how they are handling it.
 - For me, I would say that it is closed. I am the one who has to go into court. I am the one who has to go into treatment. I think it should be up to me to decide whether it should be open or closed. If it were me, I would want it closed.
 - We need to clarify the point of disagreement, what is actually at issue here.
6. If someone has been on the streets for 29 years and they say, "Leave me alone," what happens? I could see someone walking up to some people I have known for years saying, "Hi, we want to give you treatment," and they would laugh at you. What happens after outreach? You cannot 5150 them.
7. I think the potential disagreement is more complicated. There is the issue of the court hearing – who is in the room at the court hearing is simple; whatever the law is at the moment. What I think is going to be much more complicated and probably important is the exchange of information during the investigation. If the parents have said something, can the investigator say, "Well, you told me he was at this place, but how do you explain this?" and share information back. My sense is that because this is an investigation for a court proceeding subject to the discretion of the department, they have the ability to allow this to be a two-way street of information. That is where I think the family members are going to need a sense of collaboration. If they don't hear what information the team is getting so that they could say, "I understand they told you this, and his friend who always lies told you that," to the extent that the investigation can be a two-way street, I think that will make the family members feel a lot more included. The courtroom, in a way, is

easier than that, and I don't think this will be as simple and clear as who is in the courtroom.

- If I were in court, there may be things exposed there that would be very embarrassing to me, and I would not want my family members to hear some of it, because I would not want it used against me. I do feel there needs to be some privacy, but to help the consumer get help, I think a family member should be there to encourage them to get help.
8. If a petition is filed and those facts are coming to light by the attorney or the consumer, or the potential investigator may have to cite the source of the information, how would you address and mitigate potential conflicts? What would be a good outcome of this process?
- To refocus on what areas we are talking about, this process will be initiated within the context of treatment, not within the context of court, so HIPAA laws should apply. It is complicated, because the information will probably be initiated by family members or personnel in the hospital knowing that the person is not going to follow through with treatment. Any information volunteered to clinical staff or to a program cannot be blocked. I would have a question about seeking information. If they want to talk to the parents, I might have a problem with that because it might be a HIPAA violation. That is a question for the program to figure out. As I understand it, court proceedings are not whether somebody meets criteria; it is about whether it is to scare this person into engaging in treatment by virtue of having a court proceeding. It is not going to be a matter of information sharing, it will hopefully be a very collaborative, congenial conversation with the consumer asking them to give treatment a chance and telling them what will happen if they don't. I feel that if the individual does not want family members there or anybody there, I think that should be honored. If they do, that should be honored, too. I don't think it is a matter of a family member having something to say that is going to change the course of what happens in that court proceeding.
 - I believe that in the court proceeding, we would go off of evidence we have already compiled. It would all be based on the information that we would already have, and we would not be seeking additional information. As important as a family member's input and other similar things could be taken, the end input would be solely on the person educated within that response.
 - If a person is in danger of becoming gravely disabled and may not survive in the community without getting treatment, I think the treatment plan may be important to convey to the parents or caregivers, as they might be helping them carry out that treatment plan; however, I would try to consent from the individual. If not, there has to be some kind of investigation of whether the reporter is just doing it to scare them into treatment; if they are the bad guy or the good guy – to see which side is telling the truth. Then if the parents are actually trying to help the individual during the investigation, they should get the information. As far as court proceedings, I do not think that would be an issue, but if it was, I think that it could bring up things that the

consumer would not want their family to know about, and I think that should not happen.

- By statute, a lot of this information will already be available to the investigators. From one perspective, there is probate court and how those investigations are conducted in which the people involved are actually litigants in the case in petitioning for guardianship or conservatorship. This contrasts with juvenile court, where the social workers can receive any information but have to be very careful about any information that they are providing to anyone about allegations or information involving the parents or the children. I would be interested knowing what training will be provided for the investigators. I think we are going to have a lot of the information already and will not need to get that from family members. I think there will be family members who may be curious about how the investigation is going, and they might be disappointed by not getting a lot of information back other than, “Thanks for taking the time to share that with me.”
9. Regarding how often requests can be made and what happens if the person continues to deteriorate, based on my family’s experiences, I would think that three times a week minimum with the caveat that if they deteriorate, they come back even sooner. I have had situations twice where they have been out there in the morning with no problems, but by that evening they were back in the hospital. That has to be considered.

Issue #5 - Treatment Considerations:

Introduction: One thing of concern while we are currently doing program reviews of our Full-Service Partnership Program is that, by statute, it is 24/7. I have been getting a wide spectrum of response as to what that actually means, and I think for these individuals at issue, they are not going to be bringing up issues from 9 to 5. The process is prescriptive in terms of following the nationally evidence-based practice of Assertive Community Treatment. I am interested in the group’s response to the issues that are not prescriptive.

1. What is the take of behavioral health professionals on what does or should a day in the life of a person in this program look like?
 - There are two types of individuals in treatment. One type of the person who responds to AOT intervention and volunteers to come into treatment. I think that by definition, the treatment program of those who volunteer for it is going to look different than those who are court-ordered into treatment. I think the volunteer component makes a very big difference in people’s willingness to comply. Assertive Community Treatment is assertive, and it requires a great deal of monitoring, supervision, and support just to make those things happen. I think that once a decision would be made to court-order someone into treatment, there is another set of parameters that may be much more firm, and there is a different set of requirements. But whichever way it goes, whether voluntary or court-ordered, I would like to see some component where the consumer has an active role in deciding what those services are, what they are

going to participate in, what level of participation, and then the way in which they keep the court or AOT Team informed on how they do that. In Behavioral Health Court, we find that constant contact, even just phone calls, is a good connection.

- As a clarification, because we are using MHSA funds, the services will be consumer-directed, will follow the values of the Act, and the services offered must be identical for those who volunteer versus those who are court-ordered.
 - Whether voluntary or involuntary, they are still participants. I think that having a curriculum that might start out with mandatory groups, whether it be dual-diagnosis, a bipolar group, or something like NAMI Connections on Saturdays; then once they get to a point where they are stable on their medication and you see some improvement, then you can do a warm handoff to some of the community-based organizations such as the Putnam Clubhouse or Recovery Innovations or places like that. I know when people feel a sense of purpose and like they are getting something done, it really motivates them.
2. In this program, the difference between voluntary and involuntary is going to be much fuzzier than usual, because a lot of the people who agree to treatment are agreeing to treatment because they were told to do so or they would be going to court. I think somebody who is ordered by the court to participate in treatment and someone who says, “I would not have done this but for the fact that you threatened me with court,” are going to be about the same. But this program is for people who have been refusing treatment, as this is one of the criteria, so we are talking about people who are not basically inclined to be voluntary. I expect the program will be individualized anyway.
- I would like to see something that is not in this county with these patients, because they are not in treatment, is a six-month outpatient treatment program. Two examples of that are ones that are at John Muir and at Herrick Hospital. That would start at 9 am. They come, and there would be an opening where they talk about where they are at in a group setting. Then the next hour would be going to groups like a CBT or EBT group, they would perhaps work on something else. Then they would have lunch together. In the afternoon they would have a group setting and maybe some type of Alcohol or Other Drugs program, then regroup and then go home. This would provide some structure.
 - To me it looks like an upside-down pyramid. On the bottom, we have the solid, established core system, which is the end result that, as a consumer, I would want to avoid. Up higher would be focusing on all of the different ways we can try to attract people, such as with the NA concept of attraction rather than promotion. There are just some reasons and barriers that scare people from wanting to be involved. Whatever we can do on any level to lessen that is good. Maybe there could be a pool of individuals who have successfully graduated from the program and have changed their lives available for consumers to talk to them and ask whatever they want. This would require a lot of attention from a lot of people, but with a large pool of people, it becomes doable, whereas if it was one or ten individuals, it would wear them out.

Stakeholder comments:

1. I want to thank everyone for their participation, their thoughtful comments, and their involvement both now and in the future. For this to be successful, it has to be a community event. The other part is that it will be critical to get legal clarification in terms of what we are and are not able to do; whether it concerns confidentiality, engagement, or different aspects of treatment. We will need to get that done sooner rather than later so that we can actually frame a service delivery program around that.
2. What I would like to see is what was already mentioned. I was in an outpatient program for three years, and it saved my life. I was assaulted, so I didn't feel like I had a problem, but I did. That program with the staff and the other consumers that I met helped me, and I would like to see that in this county with patients. We don't have such a thing, and this is a good program.
3. If most of the information that people have in their hands throughout the process is just copies of releases that have to be managed throughout a legal standpoint, I am concerned that the content is not going to be as understandable to folks. So I hope we are developing a packet or some sort of process where the consumer as well as family members, with different packets for each, that is very understandable, available in all the languages, and is something they can refer to throughout the process when there is no one there to talk to them. It could say what their rights are and what they could expect.
4. I think it is essential that we define the 24/7 aspect of this.
5. I am passionate that patients don't see the court as the enemy and that they don't feel that when they get to court they are in trouble but that it is a potential step in helping them get better. In doing that, I want to be sure the court is prepared to be that partner. I am not quite sure that has been touched enough yet. At some point, if there is going to be a million questions by everybody, they will come right to the clerk's office and are going to want those answers. I am a bit concerned about that, but I really want the court to be a partner with everybody.
6. In my 20 years in Public Child Welfare, working with the Parent Partner program was the best thing I was ever a part of. It was also the cheapest program I was ever a part of. They were grossly underpaid for what they did, but they were well trained and well supported, and they were very integrated into the system; I think that is key. They had the experience that counted so much for the parents they worked with, but they also had some excellent training so that they provided good information and not information. That is another key in their role, and there is data to support how effective the program is.
7. I feel there should be peer involvement and peer support personnel involvement.

8. I want to be sure the information that is available 24 hours a day is current and accurate and that this program is considered a work in progress. It should not be considered a final solution immediately. I want to be assured that since the county is generally considered a progressive county that takes the lead, we continue to review, refine, and polish the process as it goes along. I don't want to forget that the people who are trained ought to have full training available that specifically addresses Alcohol and Other Drugs, because the financial resources are low and not a high priority, but it is a vital component and should not be overlooked in any treatment plan.
9. I hope that all the truly good suggestions that have been made are listened to and used to figure out how to create the collaboration. I would like to hear from at least one individual about AB 109 just to hear where they are at with it.
10. As a listener, I see a lot of passion about this in that I think that we are trying to make the wheel rounder. A wheel can only be made round once. We need to look at what other successful programs, or other programs that are being developed, are doing so we are not spinning our wheels. We need to have the professionals in this group, whether they are in law or in the mental health group, collaborate closely with other groups, especially San Francisco, since it is the county model that has been adopted here. We need to look at bringing the passion that we all have and realize that it is not going to be a perfect program but will take a lot of work from beginning to end, and that it will surely be modified even after some of the recommendation goes to the Board of Supervisors. Something has to be done that creates not only talk, but that we are actually contacting people in other places where success is occurring or where more work is occurring. I also would like to know if in our next meeting, we can have this. I am going to give David a Laura's Law summary that was put together by the NAMI group, because it summarizes it, especially when I look at words such as "collaborative" and "respectful to the people." It is part of the San Francisco Model, and we should have it as part of our packet so we know exactly what San Francisco is doing, if that is what we are going to be mimicking.
11. I would like us to not forget about out-of-county placements in long-term care facilities and in IMDs but also the licensed board and care homes and other intermediate facilities outside the county. I know there is an emphasis on AB 109, but I would like to see something along that line where family members and peer support people going out to talk to people who may be eligible to return to this county and not have to spend the rest of their lives out-of-county but get them considered as part of the AOT process.
12. I hope that the work group and county Behavioral Health leadership realize how important it is going to be for the selection of treatment teams, especially the AOT Outreach Team, based on the San Francisco model. I hope that when we come back and revisit this, we get the support of family members and can hopefully get some understanding of the court processes and how they can be more collaborative, particularly between County Counsel and family members. I think there is a difference of understanding, but they should talk to each other instead of talking past each other.

13. We have not found clear answers to a lot of the issues we have talked about. I think that is a good thing, because it is tempting to want simple and clear answers. The phrase that comes to mind is, "Simple, clear, and wrong." We are dealing with enormously difficult situations, and what I am hopeful of is that we get people who are very skilled and dedicated doing this and that we are able to give them the judgment and discretion to implement this in a way that works best for the people we are trying to help. If we take that discretion away from them, I think we will get less optimal guidelines, apart from legal guidelines that we will have to respect.
14. In implementing AOT, we have to continue to understand that this affects the most vulnerable of vulnerable populations; those who have either failed to engage and benefit from treatment for whatever reason and the families of those individuals who grieve at the pain of having a family member suffering. This is a challenge to the mental health professionals in terms of trying to treat a population that is very difficult to treat. There is a lot of passion, and we need to keep the compassion already mentioned forefront in all of our thinking.
15. I think a lot of thoughtful things have been said that are all really good. One thing I see we have in common is that we are all, at some point or another, face to face with a suffering individual and their family. That is what we really need to be together and united in how we are going to work to make sure they get the services that are needed. The second thing I am thinking is that there is a lot of passion in this room, but one of the things I get nervous about is when we take our individual passions and beat each other up with it. I think we have to lay down our roles and figure out a way to get all these roles to work for the patient. It will be a challenge, but I think that will be key to making sure that this works. I am really excited about this initiative and where we can go with it.
16. I join in the Public Defender's Office in that we see this as extremely collaborative, and that is the kind of court we want. The issues around confidentiality are always difficult in this field. As representing the Conservator's Office or the hospital or Regional Center, I have lots of interactions with parents and family members of patients, and I understand where they are coming from, but I do have to say that there is some legal framework that we have to work with here, including basically a prescription for a case plan that is in the statute. Then there is the other case law and statutory prescriptions that are in the Welfare and Institutions Code. As we move forward, the Public Defender and I will be contacting other counties to see how they are handling this. I have spoken with Nevada County. We are probably going to use their legal pleadings. I did not want to sound as though I have this bright-lined. I do think that we have to remember that in this process, as well as conservatorship or 5300, there is a right to privacy and that the client can authorize that privacy to be breached, but it is their choice.
17. I want to thank everybody for being here today. I appreciate all of the input and feedback. I love the word "compassion" being used over and over again. I love the stories about real people and real situations, urging us to continue to think about those real people as we come up with what we are going to be doing in terms of a design for programs and services, etc. It is really going to take a village, and in this case, I am very

appreciative of all of you being here and the commitment. I keep thinking about outreach and engagement, and this is where I am so appreciative of you today, Doug, because I do know about the San Francisco Care Team, and I do believe that it is going to take a team similar to that that would be available 24/7, who really understands the word “engagement,” who really understands the word “compassion,” and who really understands the word “relationship” in all of those things: who really understands the use of a peer model – thank you, Stephen. Those are the elements that I think are really critical. Thank you, Doug, for continuing to remind us that there are examples out there that we could take a look at and that we do not have to start from square one. The other thing is, in terms of a court model, we may want to look at the Homeless Court in our own community. I think there are elements that we can take from that court that provide a more human approach in terms of what some of the other communities have been doing in terms of their AOT, and we may want to take a look at that. Lastly, just to say that the word, “evaluation.” We haven’t focused on that yet, but at some point we will be talking about that. I know we will be modifying and re-modifying and having ongoing conversations even as we begin to implement, and we will come up with an evaluation plan that will hopefully allow us to really see what real people are experiencing, and that will continue to guide us.

Public Comments:

1. First, I see that everyone wants to work together here, but how do you coordinate yourselves? There may have to be some kind of a county bulletin board or something where information can be collaborated and put together, because right now you are all going to leave the meeting

I want to thank Dr. Andelman for putting us back on point on a number of occasions, as well as you, Don. Thank you very much for that. One of the things I was a little disappointed in, at least my sense on the first meeting was that in one instance, there was going to be information passed out to the AOT group so they could look at a video of other states in an actual AOT setting – not to say that this is exactly the one we want, but it would give people who are working on this work group a sense, and I don’t see that there was any followup on that. It was confirmed that that would be passed out and it was a good idea. The same thing with the San Francisco Model. That was going to be addressed today, but it wasn’t addressed other than the fact that Doug kept bringing it up. Again, this is information that is available, and this work group needs to see what it’s all about, and that is going to help you in your deliberations, so I was a little disappointed that even though it was stated that that would be a followup item on the last meeting, it wasn’t followed up.

Another thing, too, is this crisis mobile team, which, again, is something that we have talked about for years, and I know, for instance, that the police officers in LA County who participated in outcalls became so familiar with their clients, so to speak, that it was a very friendly relationship. I believe Concord has a designated individual who does make all of these calls to this, and that is very helpful, because they understand the

situation. I realize our county does try to get CIT training across, but again, that is very important, and I know that we have another class coming up, but that is extremely important.

Although I had a few shots at the county for not following up on a couple of items, I do want to thank you guys for putting on this program and all the work that has gone into putting this together. It is really very wonderful that we have everybody here and working together. Thank you, Sean and Steve, for some of your comments.

2. I know it was brought up that Contra Costa is unique, but when we really look at the people in this county who are living with mental illness, they are not unique in that their emotions, their struggles, and their challenges are universal. So it is them we are here for, and we have to make our county bend to their health, however unique we may think we are. I was a little disappointed today, too, because I thought that maybe it would be a good idea to collaborate with all these other counties that are working on the same issues that we are, and it might have been helpful today if we would have had some representatives from Nevada County, which is the only county that has had this in place for any length of time. I think some of our questions would have been answered as to how they are handling them, which doesn't mean we have to handle them that way, but it does give us some guidelines. Some of the court questions could have probably been answered in some degree as to what they do, which might have helped us, too. So I really think it is important for us to collaborate with other people who are working on the same thing. I am sure they have very much the same issues.

So when I look at AOT and first got involved with the first AOT workshop, I looked at AOT as creating a trusting, caring, listening, compassionate support team for our ill loved ones, which they don't have now. I look at these teams, because when I am looking at the whole process, I think we aren't talking about one team; I think we are talking about multiple teams. What I saw is very flexible teams and individualized treatment. Each person living with mental illness has their own issues, and they need to be addressed. They have their own people that they will respond to, and that has to be taken into consideration. Being a family member and being very involved with family programs, I realize that the families I see who come to my support groups and programs are loving, caring families who want to help. This isn't the case all the time, so when we talk about having families involved, for some individuals, it may not be a good thing. So I think we have to really keep all this in mind. Who are the people who are going to help that person? I think that person has a big choice in who their support team is. These are the people they will relate to. These are the people who they can cry on their shoulder. These are the people they can go to. These are the people who are going to love them. This is not a short-term thing. I think we are all finding out that mental illness is a long-term treatment. So we need to create these teams and these support groups that our mentally ill can relate to. I know that Duane brought up something that kind of struck me about, what if you have that person who has been on the street for many years, and you go up to them and they say whatever they say. We have to remember that AOT has criteria. Not everybody is going to fit those criteria to get into this program, so there are people who aren't going to fit the criteria, and there are people who we are not going to

be able to reach, but we have to try. We have to try. That is our role. We have to try, because we found that what we're doing now is not helping an awful lot of people, and they are there. I am looking at AOT as offering a kinder, gentler treatment option for those who are living with mental illness, and I am hoping that in this county, we can put all these wonderful minds together in this work and we can pull this off, because this, I feel, is just the beginning.

Stakeholder Taskings: Comments by Warren:

One of the things that you may have noticed is that, due to the talent and diverse stakeholder representation, we are actually, in addition to getting input, team-building. This will continue as we build this. I want to stress that this forum is only one item, and that we will be reaching out individually. We will be expecting you to reach out to us individually around specific issues. The second is that for May 19, same time, same place, about a week ahead of time, you are going to get another blizzard of information. It was mentioned that there are some documents that we had promised to get out to everybody. You will get those, including a summary transcript of what we all talked about here, and you will get a draft program design. I want to manage your expectation about this draft program design, because when you look at it, you are going to see holes, you are going to see it's kind of sparse. What we are wanting to do is like we did today – have you get the documents, look them over, compare with the other documents you are getting and the information you have, and bring to the meeting what you want to see embellished, filled in, what was missed, what you think is wrong. So we are looking forward to a really lively discussion in that this preliminary program design really should be the bones, and that you actually flesh out a lot of what we have talked about. I can tell you, there will be a chapter or a section in there about issues for resolution, and we have surfaced some today, some last week. We may surface more. That then becomes our script for what we need to work off as we get to actually launching this thing. We are going to start putting that draft design together.

One thought I want to leave you with is that I would say probably 80% of the discussion that we have gotten here and last week was really around how well we do it; not whether we are going through Door #1 or Door #2. There were discussions around that. If you know my style in generating these things, I am a little sparse with adjectives to the point where sometimes people will say, "How did you get from here to there?" And that's what's really going to be helpful, is where, with who you represent, you need something spelled out, or you need this value infused there where it is not there. I want to prime you to what you will get, probably in a couple of weeks, and we will have information about the San Francisco Model. We will build into the agenda on the 19th a little video that Doug has where you can actually see what it looks like in another locale. So we should have a very full agenda. Thank you all so much.

Respectfully submitted,
Melinda Meahan

AOT Workgroup Summary, May 19, 2015

David welcomed the group, gave a brief orientation to the reason for this meeting, and provided instructions for those wishing to speak.

The group viewed a 4-minute video provided by Douglas Dunn showing an example of how one assisted outpatient treatment court works.

Warren reiterated that the purpose of this meeting was to provide input on a draft program design. He clarified that the documents provided about the San Francisco model were for reference purposes, as San Francisco was roughly at the same point of design that we are. He gave a 10-minute overview of how our model compares to the San Francisco model, covering each of the five major areas – Referral, eligibility, the legal process, outreach and engagement, and the actual treatment – and why any differences were proposed.

Workgroup participants provided the following comments and questions:

Agenda Item 3: Introduction and Table of Contents

1. As a union representative, when I hear “contracting out,” it is of concern to us. To what extent does this model create new responsibilities that would be contracted out as opposed to being the responsibility of current staff performing these functions? How will this affect the work of Contra Costa County employees, family partners, and others who are bargaining unit employees?
 - In terms of determining eligibility and navigating through the legal process, that is new and will have to come back to you between now and implementation, because you will want to match it against bargaining units. We had an eye toward that particular part and purposely designed it to try to stay inside the lines of what would be acceptable in terms of current bargaining unit agreements.
2. Contracting out takes away the responsibility of the county. I am concerned that the county will consider it the contractor’s job and the contractor will consider it the county’s job, and the consumers will suffer.
 - This is why we blended the team.
3. In the San Francisco model, the care team does initial outreach and engagement, but it’s far more circumscribed, 9-5 Monday-Friday. What about the handoff of responsibility within the contracted team?

Agenda Item 4: The Care Team

1. I am concerned about the care team, especially the psychiatrists prescribing medications who spend 16 hours a week looking over 75 patients. I am concerned that this person needs to be knowledgeable about up-to-date medications. There are new medications that actually help people with anger issues and don’t heavily medicate them. I am concerned that the psychiatrist should have current training and not be set in older ways, such as thinking that everyone needs to be on Abilify.
2. I think that we should not contract out the care team. We should keep it in the county, because it could save a lot of money.

3. There is an estimated 37 people eligible for AOT. How many care teams will there be, and how many consumers will each care team be serving?
 - Warren: I believe the ACT contractor makeup is 12 to 13 people total.
4. I noted that the Board order said the program would begin November 1. The program design overview states it will begin in December. This could cause problems because when you get into the holiday seasons, bad things happen to families. I would recommend that out of the San Francisco implementation procedures, steps 4 through 8 be included in our plan, whether it is contracted or not, because it seems to be a good process and seems to work for San Francisco.
 - Warren: Steps 4 through 8 are straight out of the statute. We are happy to put that in if it makes people feel like it is there.
5. In the initial group, is the licensed clinician part of the team, or are there four people involved: the ACT person and clinician, family partner, and peer partner?
 - The care team is one team that has a County licensed clinician and ACT Team membership usually will be the family member and peer provider. They act as one team. It can be four people but normally would be three. Sometimes it could be two depending on what they are responding to.
6. Will the care team be delegating work to the treatment team?
 - Correct.
7. Could you briefly explain the role of the family partner?
 - This is briefly described in the documents may need to be fleshed out more before it is put out for bid. Their primary responsibility is to respond to the loved ones and family who is surrounding the individual being referred. This was powered by family members who feel left out and want a liaison who can help them be a part of the treatment. We have a model in our Children's section that is a good example we can use.
8. I have a question about safety for everybody involved. What is the role of the clinician and all the people involved, and how is it different than what is done now, and what safety measures are used?
 - Warren: This is discussed in Appendix D. I felt it needed more discussion and working with law enforcement and County Counsel. In a full-service partnership in Contra Costa County, they will have exclusionary items in the scope of work, where if a treatment provider feels not safe and can show evidence that it is not safe, they can elect to not serve the client. This does not apply in an assertive community treatment model, so this will need to be worked on.
9. How does Contra Costa define a licensed clinician compared to the Ph.D. level definition in the San Francisco model?
 - Warren: Contra Costa County honors five guilds: Licensed Clinical Psychologist, Licensed Clinical Social Worker, Marriage and Family Therapist, Psychiatrist, And Psychiatric Nurse Practitioner. There is an LPCC that is gradually working its way

- into the system, but it is not in Contra Costa yet. San Francisco operates off the same model we do, but the person they hired as their full-time AOT director, she happened to be a Licensed Clinical Psychologist.
- David: In the Contra Costa Model, the classification is Mental Health Clinical Specialist, and the job description as it relates to this assignment is one of the issues for resolution.
10. For safety, I would recommend that law enforcement be part of care management in the ACT model. Many ACT models include that. They include probation officers, law enforcement officers, public defenders, and district attorneys. For safety issues, I think it should incorporate that so it is an obvious part of the model.
 11. The description of roles seems not to be clearly delineated. I would encourage Contra Costa to delineate those responsibilities as much as possible. This gets into the legal process, but I note that in the Contra Costa model, it looks like one person – the clinical specialist – makes the determination as to whether the person meets criteria for AOT, whereas in the San Francisco model, three people heavily influence that determination.
 - Warren: This team will heavily influence the eligibility process, just like San Francisco. The CCBHS Team contains two licensed clinicians, so that you have cross-training and overlap, so if one is not available the other is. There is also a 1/4-time Mental Health Program Supervisor who provides a check and balance, so there is more built in than just one single person.
 12. I am concerned that communication between contractors and the County case managers or other people who work at clinics is clear and that there is a process for it. I have seen problems when contract agencies have been used before and don't want to see that repeated.
 13. Will family members' concerns or complaints or those of the person being referred be directed to a family advocate or to Patient Rights?
 14. A lot of consumers are afraid of law enforcement. If law enforcement had a view that this is a patient, and not a suspect or subject, consumers might be more open to law enforcement. I think this is one thing lacking in law enforcement that I would like to see improved.

Agenda Item 5: The Legal Process

1. In theory having one sole investigator or clinician making the decision to file a petition should work. In practice, there has been too loose coordination between county and community-based organization contractors, and I am afraid that could happen with this model as well. We should make sure that there are multiple parties involved in this process.
2. Regarding the statement on page 9, "Law enforcement presence from the appropriate jurisdiction may be requested," I think that the only time law enforcement should be involved is if there is some criminality to the individual and a sense of danger. In that case

there should be law enforcement involvement; however, if there is no danger of harm to self or harm to others, which would meet 5150 criteria, I do not see why there should be that much emphasis on law enforcement.

3. I would like to see law enforcement talking to consumers more. I am afraid of law enforcement, but I do talk to them all the time and it seems that it has helped me become more comfortable with them. It would be nice to see law enforcement sitting down and talking to consumers so consumers could see that there is a care.
4. The investigation section talks about the Contra Costa Behavioral Health Team authorizing representatives of the care team outreach and engagement for up to 3 times a week. I would like to see that at least 3 times per week for up to 4 weeks with an additional sentence added, “Daily contact will be authorized if the person is experiencing significant further deterioration.” That is right out of the statute.
5. Regarding the court hearing section at the bottom of page 10, it talks about if the person can survive safely in the community. The statute goes into where it says another 180 days can be added, and I would like to suggest that language be specifically included that another 180 days can be added if they judge that the person still meets AOT criteria.
6. Whose role will it be to issue a summons to appear?
 - That is already included under pending issues.
 - In the San Francisco model, I believe the care team serves the summons.
7. In the Court Hearing section, it says a public defender will be assigned by the court. By statute, the public defender becomes the attorney for the patient at the time the petition is filed, and there is no requirement that a public defender be assigned by the Court. As the Public Defender, I designate who is going to take the case, but we are already a party at that point.
8. In the last sentence on the same paragraph, it says, “Those persons receiving the Notice of Hearing will be in a position to contact and advise the client.” I have no idea what that means.
 - This is a sentence in the W&I code that identifies who should be getting the notice. I believe the code says the representing attorney, Patient’s Rights, and the individual.
 - Is this for legal advice, court counseling, or what?
9. I would like to suggest that hearings and court proceedings be moved out of an imposing courtroom setting and maybe into a less imposing room in order to take the fear factor out of it.
 - Going to a different room can be a problem for the court. We are trying to keep the cost down by saying we will tack this onto the end of the LPS calendar. To suddenly have this occurring in a completely different setting may logistically be a lot harder than it sounds like it would be.
10. In reference to comments about a collaborative courtroom, on page 10, the second sentence of the second paragraph says, “The optimal court setting should be as normalized as possible in order to mitigate the potential traumatizing effects of a courtroom setting that is

associated with criminal cases.” I don’t think that statement necessarily captures what has been fed back in the community groups by those people who have been involved in the process. Could that be worded differently so that someone who has never seen, heard, or discussed this before could understand that? Perhaps calling it a collaborative courtroom or a less formal courtroom would describe it better for an outside person who has never been part of these discussions.

11. I think it is important to define what part the Patient’s Rights Program plays. We are prohibited from duplicating the efforts of the Public Defender’s Office and don’t have the same type of training. I would not want to see any confusion caused by lack of clarity about their roles.
12. County Counsel had questioned the closed and confidential court hearing. County Counsel was going to research that. Has that been determined yet?
 - That is still an open item.
13. There are probably a wide variety of visions of what the court hearing would look like, what kind of room it would be in. I don’t know if the actual experience or what happens will match any of our visions. I appreciate comments by people who are trying to get to language that says, “least intimidating,” or “most engaging,” or “least traumatic,” to try to find the right words to define what it might look like. A presiding judge was at the last meeting and would have appreciated those comments. As far as what would be possible, other people will weigh in on that. The judge hearing the case will weigh in on that. The Sheriff’s deputies and the bailiff will be responsible for safety and will weigh in on that. We have physical limitations at our courthouses. Some of them are quite old, and we only have so much space. These things will be considered, and the court appreciates the spirit of what people are hoping for. We will do the best we can, but I am not sure it will look like any of our visions.
14. In Contra Costa County, is there a [plain] room in the courthouse, or will you go into a courtroom? If so, would the consumer sit on the prosecuting side or the defense? This is a big difference compared to what I have seen in Oakland, when I was in a hearing room with just a table, which was less fear-inducing than when I was in a courtroom where the judge was at the front.
 - The setting would partly depend on what is happening at that point in the person’s case, if it is a case yet. A lot of this will be discussion, and that can take place around a table or maybe in a jury deliberation room or conference room. That is possible; however, there may be a time in some situations where there is a contested hearing with parties making arguments to a judge who has to make a decision, and that is probably a hearing that will have to be open to the public and held in a courtroom. If that is the situation, the consumer would be on the defense side of the table.
15. San Francisco thinks that their AOT court proceedings will be presumed closed because of the referred person’s sensitive mental health information that will be shared.
16. Assuming that our system works as well as other have, the funds budgeted will turn out to be far more than is needed. I understand that budgeting going into the process, you have to be conservative, but it may end up being a lot less than what is budgeted.

Agenda Item 6: The Treatment Model

1. Will family and peer providers be part of the treatment model?
 - This is built in.
2. To what length will the ACT treatment team continue treatment? Is there a limit on treatment like there is on outreach and engagement? Is there long-term followup and having the person feel like even after some stabilization, they still have a team they can go to for additional resources?
 - The statute says that treatment can be up to 6 months at a time, and you can ask for another 6 months. As far as stepdown, that has not been solved and needs to be worked on. We ask about stepdown plans in full-service partnership reviews. We are building in a flex fund to address directly providing a roof in a housing-first model. What happens is that when the ACT Team says they no longer need an intense level of services any more, there is still an ongoing financial and legal commitment to maintain things like housing subsidies that were coming out of the ACT teams' flex funds, and that is an issue contained in Appendix D, as the Board says we need to figure out what that will actually cost. It is part of the stepdown process or exit planning.
3. One additional section I believe needs to be added is a report section showing what the team has to report back to the provider.
 - This is right out of the statute, and we are happy to do that.
4. The Scope of Services on page 13 needs to have added something to the effect that the maximum number of possible court-ordered AOT positions is capped at 37 persons.
 - If we are going to rephrase the model to state it has a cap of 37 individuals that would be court-ordered, this would have program implications.
 - The second work group last year agreed on a number of 37 persons for AOT. When we went to 75, we assumed that half of them would accept an FSP, which would show that voluntary services are not being cut to fund the program.
 - *[NOTE: Based on a discussion later in the meeting, the original speaker rescinded their request to specify a cap of 37 persons.]*
5. If a participant jumps ship [goes AWOL, walks away from program] and ends services early on their own recognizance. What does the treatment team do to get them back into treatment so they can continue to receive services if they don't meet 5150 criteria?
 - This is a difference between models. The ACT team has a responsibility for referral and outreach, so if someone stops participating, it is built into their contract that they have to go out and continue to try to get them to come back. The Nevada County model has that, because they control the whole process. The proposed San Francisco model is bifurcated, and that needs to be an issue.
6. I think what would save money is if the AOT program was run by the County instead of contracting it out, as the care team would be right there. A lot of psychiatric patients do

not like changes, and if they see the same person, it gives them confidence that they are being cared for. The AOT program should be kept within the County as much as possible except for such things as contracting out drug and alcohol services. There are other situations where contracting services out has caused us to fail patients.

7. Will the psychiatrist and the nurse in the ACT Team be contract providers or County employees?
 - They will be County employees.
8. I would like to confirm that the number of 37 was based upon an extensive study that found 37 people in the county who would qualify for AOT. If we are looking at processing 37 people in the first year, based on the history of other counties, it is likely that maybe half of them won't need a court filing. That is why it appears that there will not be much court work.
 - At one point in time, we identified 37 people who had already been offered services, and we would need to file a petition on them. We know there are another 37 persons who will meet criteria and have partially engaged in services. The 37 people are ones we have been spending a lot of outreach on and have not had traction.
 - I don't see how you can know that. Once the team goes out and presents them with the threat, part of the black-robe effect is fear. When they are told that they will need to go into treatment or they will be hauled into court, it seems likely that a fair number will say that they hate going to court, that they were in court that it was horrible – rational people all avoid courts. I believe that number is fluid at this point and will be whatever it turns out to be.
 - I do not like the idea of a cap. It appears that we are setting up a 3-year program by the time we get it operating, make adjustments, and deal with budget issues. If we set a cap of 37, I am sure that at some point a 38th person will appear, and the services would be available because other people have dropped out, but someone will exclude them because they have a cap of 37.
 - I think it would be impossible to count the number of people who are actively in a program at any given time to tell who is #37 and who is #38. I think at one point someone proposed a steering committee to oversee the whole program. It might be up to that committee to decide if they are at capacity. I think that is what should drive limitations as opposed to a fixed number. We only used the number as a goalpost to roughly come up with the anticipated workload.
9. If a person accepts treatment and subsequently decides they don't want treatment any more, they can easily just go to a different county like a number of our clients do already. Who will become responsible for that person then?
 - No county has authority to place a 5150 hold outside the county boundaries. This is further complicated by the fact that in this county, the only staff who can initiate a 5150 hold other than law enforcement is a number of licensed clinicians who are County staff. Providers cannot do that. I am not speaking for law enforcement, but to go into another county on a civil matter may be challenging.
10. If someone goes to apply for or already had SSI benefits, it is important to have a

long-range goal to make sure the client does not get in trouble with the Social Security Administration for things like getting overpayments or if they try to go to work. The program will need to provide benefits counseling and also to keep them in housing later.

11. If someone walks away and are out of sight for six months and there is a potential for a new petition, how will that be taken into consideration?
 - That is listed as an issue that needs to be resolved.
12. I think we need to realize that we cannot turn people away. When a family member or loved one petitions for this, we are going to have to find a way to meet that need. If we don't meet that need, we are putting that person's life and their families' lives at risk.
13. With regard to the 75 persons who are eligible for the program, what is the impact of work on current county employees? What proportion of those 75 clients are included in our current client base? How can we compare how this will impact the current operations?
 - The number 75 was arrived at as those persons we could identify who are currently in the system who roughly met eligibility criteria.
 - What proportion of the current client base is that 75?
 - We currently have 10,000 adults and 6,500 children.

Agenda Item 7: Communicating AOT

Before taking questions and comments, Warren explained that this is a less developed section of the plan and that he hopes to get good input in order to develop it.

1. San Francisco's statement that the care team will be responsible may be nice in theory, but the Director will actually be responsible. In terms of a budget and budget summary, I have put together some alternative scenarios, and one that I think Contra Costa should look at is making one of the licensed clinicians a full-time AOT program manager. That might be a way of getting the word out and dealing with the communications budget, although it might be incomplete, imprecise, and unsatisfactory, but it is something to think about.
2. I am worried about the role of consumer providers or anyone who is not licensed who is hired as a contractor. Whether this program ends in 3 years or even if it continues, how will these people continue to get medical benefits? This is one of the most complicated subjects, because we won't have retirement as part of an agency, and it is really difficult to navigate the Social Security Administration and be able to provide health care for yourself.
3. I would like to recommend at least one or up to 3 walkthroughs, where you would create a few programs for people who might go through the process. Perhaps other counties could provide some profiles, and a group could work through the process from start to end.

Agenda Item 8: The Evaluation Design

1. Under the Hypothesis heading, I think there needs to be one more category added: Enter into a voluntary settlement agreement and participate in treatment with the ACT team. I

think there are at least three other areas that you need to capture. As far as families are concerned, this is considered a crisis service as well, so those would be the number of days of psychiatric ward or crisis residential facility [e.g. Niereka House] stays, any conservatorship one year or less days, and any possible LPS and Forensics state hospital stays. If that could be captured, that would be helpful.

2. Regarding evaluation of the treatment model, I have a comment about in the film where they talked about people graduating. For some people, graduation can also feel like abandonment, so at the end of treatment, what happens after that? From a clinical and relational point of view, I am interested in what support the person gets once the team has “graduated” them and think it should also be included in evaluating the plan.
3. I am assuming that a successful outcome of the AOT process is that the person gets folded into a full service partnership and is using clinics and whatever services are already established rather than needing anything outside of that, and that would be the ultimate goal. The question for the stepdown is how to integrate that person back into the FSP or system of care, and what way do we do any long-term followup both in terms of data collection and in terms of keeping people connected.
4. I was in a treatment program for 3 years, and before exiting, they help you work into the community. They also make sure that you have a therapist and that you are in some kind of group thing. They make sure you have support on the outside. They do a lot of family stuff so you have someone checking up on you. They also have a plan that if you do fall, there is a set plan of what to do if you are in a crisis. These are all the things they should work out in AOT – if you are in a crisis situation, what you need to do – so at the time you are exiting the program, you are in a part-time setting or out into the community a little bit doing things you will be doing, and you can come back and tell them what you are running into and get lots of help.
 - So you are saying discharge planning should start at day 1.
5. After the three years of the program have been completed, is that when you do the evaluation?
 - No, the evaluation starts on day 1.

Agenda Item 9: Implementation Timeline

1. The timeline that we agreed to in the Board order brings me back to the question about what it says in the program design overview.
2. What are the timeline and the focus, and how quickly do you want this up and running? I see that there is a lot of work to be done.
 - I hope everybody recognizes that this is a best-case scenario without any major hiccups. This can be discussed more when we talk about what’s next. I would like input from people around what they want to see happen and their participation or not in those events. If we hit something that is a major roadblock, we don’t want to be making that decision by ourselves and then have people ask 5-6 months later why it was delayed.

3. On item 4, “Award contract to ACT provider,” San Francisco hopes to hire their care team staff by July or early August so they have at least 90 days of training. From September to November is about 60 days. Would it be possible to try to award the contract sometime in August?
 - It is a physical impossibility.

Agenda Item 10: Budget Summary

1. How much does the San Francisco team cost versus the Contra Costa County team, and are we saving money with our model?
 - San Francisco has not yet figured out what it is going to cost them. What they have budgeted is three county positions. They have hired one, the Director. They are in the process of adding two more County positions, which would be the family partner and the peer provider. They have figured out that they are going to use an existing full service partner contract provider in the City, but they realize that it is not the full spectrum that the law requires and that they will need to enhance it, and they have not yet figured out what that enhancement is and how much it is going to cost. What we know is what you see in the document.
 - San Francisco has come up with somewhat of a cost per person, but that is as far as they have gotten. We have gotten much further down the line than they have.
 - When we were doing staff work in preparation to go to the Board, we looked at what Contra Costa County’s full-cost recovery was for one FSP, and it was between \$35,000-40,000. When you take that \$2.4 million in the budget and divide it by 75, it comes out to about that. That benchmark was useful to make sure we were not overbuilding or spending too much or underfunding it so we could not do the full spectrum of service.
2. Since we keep referring to the San Francisco model, is that available publically, and can we get copies of it? And are they at the same stage as Contra Costa in terms of planning?
 - We have been getting copies of their materials online. They are roughly at the same point we are, but we are ahead of them.
 - Is Nevada County any further than we are?
 - Nevada County has one contract provider who does all of those processes, and it costs \$1.9 million. They have a case load of about 90 people, and they get 2 to 3 new people a month.
3. The job of the team is different than for inpatient or voluntary outpatient consumers, and I imagine that specialized training for this does not necessarily exist. I think compare-and-contrast communicating to other counties who are also doing this should be used as part of training. I know that training is often overlooked in budgeting, but funding initial training and ongoing training and support for the providers is crucial for this type of work.
4. Part of the evaluation of going to be looking from county to county on what the different

challenges are financially as well as programmatically. For example, for San Francisco, it is being a single city-county. Each county has the ability to leverage different resources differently, whether it is housing stock, using a contracted hospital as Nevada County is doing as opposed to a County hospital, wages, and so on. As we go into this and do so mindfully, we will want to put our plans up against each other so that we can evaluate it down the road.

5. How did you come up with the Contra Costa Behavioral Health Services team oversight model? Specifically, how did you arrive at one person who is quarter-time plus two full-time people, and then the shift to the contracted care team and AOT treatment team?
 - Like San Francisco, we wanted the lead responsibility for referral, eligibility, and the legal process. Unlike San Francisco, we want redundancy, so we came up with the idea for two full-time people. For budgets in public service, there is a footprint that supports the two clinicians and an important check-and-balance between the clinician and the next level, which is management. That is the one-quarter Mental Health Program Supervisor. There is a boatload of clerical and administrative support needed. That is where we put in the clerical support as well. Those are 0.25 FTE each. That will be embedded, and we will need to sort out if that belongs in the forensics team or the transition team, but it will be part of a team that we will definitely need to augment staffing-wise in order to take on the increased work load, just like the Public Defender, the courts, and County Counsel. We are looking at the total impact on a County unit that would inherit this new work load.
 - There are also other activities that are not as visible, such as the management team cosigning the petitions. So it is not just the clinician and the investigator. There is also utilization review and quality assurance of the treatment being provided by the FSP. There are other things that are not leaping off the page but that are part of the daily operations.
6. Some of us have heard the numbers from Nevada County and multiplied them and felt we would have a lot more cases here. I remember Doug explaining to me that the San Francisco model included some extra requirements before someone gets into the AOT program, such as extravoluntary engagement opportunities. Are we adopting those here?
 - Would they have to be 5150'd?
 - No, it is not just pre-5150 because of civil liberties issues. We agreed with San Francisco that they have to meet 5150 criteria before they go in the hospital. Nevada County and Orange County are different in that.
 - So our number is somewhat lower because we don't have that barrier?
 - So what are those additional criteria?
 - Multiple engagements – the treatment team goes out and tries to engage the person voluntarily. If they agree voluntarily, they are in the program, and there is no court process. If they go to the court process and agree to services, the court process stops. That is unique about the San Francisco model. In Nevada, Orange, or Los Angeles counties, that would not be the case. It is just in the San Francisco program design that at any point the person agrees to voluntary services, all legal processes stop.

- We will have to clarify that, because there is a difference between an individual meeting the AOT legal criteria and the legal floor, and they can still voluntarily engage in services, but they still meet that legal floor. That is more of a legal question we may need to clarify.
7. On this document for fiscal year 2016-2017, the court is given an additional \$128 thousand, and the Board of Supervisors was very clear that they were giving us a one-time funding for 2015-2016.
 8. If you have a person they are putting on a 5150 but by the time they get to the hospital, they have cleared up, which happens a lot, what do you do at that point? I ask because I just saw one person last week who was sent to the hospital four times but who is now back on the street.
 - I think that is the population we are focusing on, those who don't meet 5150 criteria at the time they are in the hospital but have a pattern of hospitalizations and so potentially become eligible for referral for this program. These are the people we want to identify.
 - If they are identified as needing this program but they cannot meet 5150 criteria, how do we make them do the outpatient treatment?
 - There will be some individuals who will cycle in and out of PES that may end up in the hospital, and that is where we will engage them. We will try to engage them prior to hospitalization, but those who are cycling in and out of the hospital are the ones we will want to pursue as well.
 9. I believe there is another typo – the Public Defender should be \$133,500, and the total for County general fund should be \$418,500; and the following year should also be corrected.
 10. Does the department feel confident that a quarter-time program manager oversight over the clinicians is sufficient management oversight of the program?
 - Not everybody will agree on this. One thing that might impact this is when we get a communication plan and find out to what degree County Behavioral Health people are responsible for communicating with the public and with stakeholders, because that may influence it. In our analysis, we came up with 0.25 FTE staff for supervision of the program, but other things may influence it.
 - Also, it may be more intensive during the first year as we develop this, and we recognize that as well.
 - For efficacy, the better you can maximize all the other parts, then the real management and supervision component of this is about the quality of service to the consumer and their loved ones. More focus percentage-wise needs to be engaging and working and fewer meetings, talking and presenting. That involves a tradeoff. We hope to fill the care team with amazing people, and everyone will want to talk to them. At some point the manager and supervisor will say that there is no benefit in giving the public access to them, but they need to be working. That is why they won't go to meetings but will be working. We can hear from line staff what that feels like, and they can get burnt out, too.

Agenda Item 11: Appendix D – Issues for Resolution

1. I anticipate a number of folks who go into voluntary treatment and then leave that. When the assessment piece gets frozen, do they become involuntary or does the process start over?
 - If you look at the legal workflow on page E-2, where it talks about the AOT process stopping with no petition filed, there is a point where you file a petition or not, but once it goes forward, then the system takes over. I am unsure whether the case is dismissed once the person is under court supervision and then is participating. I think that what stage in the process the person voluntarily accepts will determine what happens next.
2. If they go through a court process, will this go on their record, such as civil suits that can be reflected on your credit record?
 - It would not be like small claims proceedings that are available to the public. They would be confidential, similar to LPS hearings that are confidential and cannot be accessed by the public.
 - This fact needs to be made clear to the consumer.
3. What is the recidivism rate, such as when a person completes AOT but has an attitude that they are in this involuntarily but when they are done they will go back to what they were doing before?
 - We will need to capture that information.
4. I would recommend that after a certain number of clients, perhaps 5, or a certain number of months, you should build into the evaluation and implementation a review process where everybody sits down and looks at what policies and procedures have been working, what communications problems you had, what were some of the unanticipated outcomes, bumps in the roads, AWOLs, etc. At that point, you may want to revise the policies and procedures, beef up communications plans, etc. If that is built in up front, when you look at the evaluation design, it essentially looks at the pilot project as well as what happens after that, so there is room for making major programmatic changes as well as minor policy and procedure changes.
5. What are the conditions and protocol for asking for civil standby when it is determined to be unsafe? My recommendation from a law enforcement perspective would be that first, if you identify someone you may have issues with based on their history, you should provide some type of beat information to us. What other agencies do when they come into our jurisdiction is to contact Dispatch and advise us that they are going to be at a particular address contacting a particular individual. This gives us the ability to be in the area and gives us a forewarning of what is taking place. Then if you need to call 911 via cell phone or a landline, we are already aware of what is going on and know what we are coming into. As far as civil standby, we would recommend that if you have the ability to give us some type of timeline it would be better than just calling dispatch and having us stand there for some period of time and having to wait for you to show up. There have been a lot of suggestions on how we handle civil standby. Unfortunately, we will have to be uniformed; however, we can give consideration such as by meeting the deputy down the

street to give some understanding. The last component would be that if you give us some type of timeline in advance, we may be able to provide a CIT-trained employee versus one that is not. We are in the process of giving all of our employees CIT training, but it just takes time to get all of the deputies through that process. We are offering a small block of that training to all deputies coming out on patrol so that when they go through the field training program, they are at least exposed to it before they can go through the entire course.

- For example, in an unincorporated area, we could call a deputy and coordinate and prepare a time to arrive at the residence. That is possible mostly in unincorporated areas, but it is a different situation for incorporated areas with larger departments.
6. In West, Central, and East County, there is a Forensics team that meets on a regular basis. I am hoping the Sheriff is included so that you will know these people anyway, because they might be regular callers. I feel that the civil standby should be done by a CIT-trained officer as much as possible.
- There may be circumstances that dictate otherwise, but we are aiming for this as much as possible.
 - This speaks to the planned intervention and the outreach model versus a crisis responding model. We expect that we can plan it, and get everything ready so we can offer rapidly. That is a prepared response that is different from a crisis response such as a 5150. We are not replacing the 5150 process but are augmenting it.
7. I feel that unless the patient does something that breaks the law, in which case they become a criminal and need to go handcuffed into a patrol car, they should be treated a patient and should be transported in an ambulance.
- This is a civil process from an outreach team offering care. If there was a need for a 5150, our process is to have them transported via ambulance to PES. At times it is helpful to have the officer a part of the conversation. If there is penal code behavior, then it would not be a mental health decision and would become a law enforcement conversation.
 - It is the Sheriff Department's policy not to transport patients in patrol cars but to send them by ambulance.
 - I have seen some law enforcement agencies within the County who have transferred children in the back of their patrol car.
 - Law enforcement standby is great when the CIT-trained people come out. What we see come out of these kinds of encounters is a 148 or a 69, which is a criminal charge of some type of altercation with a law enforcement officer. That often comes about because the person is having a psychotic break type of episode, which does become complicated, because there may be a criminal filing, but there didn't have to be one.
8. Will the clinician and the investigator have access to medical records? If the clinician is able to see the consumer's triggers and their previous experiences that may have led to a 5150 or arrest, we could try to ameliorate that as long as we have access to records.
- There is also a decision point on the part of law enforcement about whether they are

brought to the attention of the District Attorney for a criminal violation.

- We should add to these issues how many AOT calls within the police department they will file with the District Attorney.
 - In talking with Richmond police officers, knowing the person and their triggers has helped in preventing triggers. When they know the patient's history and background, they can prevent another trigger.
9. It seems that the care team will be critical for so many aspects of the effectiveness of this. I like the idea that it will not be a cookie-cutter care team, but there will be an attempt to put together a care team that best fits a particular individual being referred. There should be some fleshing out of who will make the decision to pick the care team and what criteria they should be looking for.

Agenda Item 12: All other Appendices

1. I was not sure that the items on the 5 pages I sent in were covered adequately in the April 30 meeting, particularly what the treatment would look like.

Agenda Item 13: Public Comment

1. On the implementation timeline on page 21, I think we need to be cognizant of the deadline of September to fill County positions. I think we have to move positively and quickly to fill the positions that are going to be crucial to this – the case manager positions, the family advocate positions filled, and the family coordinator positions filled. If we are going to interface with a community-based organization, the County has to have an excellent team in place, or this is not going to work well.
2. One appendix that was not included in this packet that we saw in the pre-Laura's Law workgroups was about Kendra's law. Laura's Law is modeled after Kendra's Law, which has been working since about 1998, and the program almost stops recidivism. Also, a portion of Los Angeles County has had an AOT program for about three years, and they have similar statistics. The San Antonio model also has similar statistics. They show that assertive outpatient treatment really helps the seriously mentally ill. We need to realize that the court system plays an integral part in this. Many times, the judge is a kingpin of how this works, and the judge should be the person who is making the decision of whether the person should stay in treatment with input from the care team. It should not be the individual, or the individual will be running through the revolving door again and again. It is a work of art, because we have to honor the seriously ill persons' rights and ability to interact in this. The crucial part is very good care and treatment teams that constantly interface with the judge, and they need to meet before they have the first person in AOT Court.
3. How are veterans brought into the system? Are they redirected into the VA system? Will there be any dialogue between the VA and the care team? Will their care after the six months be handed over to the VA or become part of the AOT system?
4. The treatment model on page 13 briefly touches on family support and education. I have

heard very little comment on the role of the family in this model. What exactly is the role of the family or caregiver in this treatment plan? Is family support and education merely window dressing, or will family and caregivers be involved in this program? Does part of the treatment goals involve family members or caregivers, who are the one dealing with these issues after we are all gone? Also, what happens to family and caregivers and the person receiving services after the six months is over?

5. I have been involved with the mental health system since 1974 and even before owing to a very traumatic circumstance. As a result of my experience, I don't believe that six months is adequate to treat people who are seriously mentally ill. It is hard to understand what is going on with them. It is hard to contain their violence. You don't always know what to do in an intense situation. Decades later, we are still working on the situation I faced, and I have felt very little support from anybody except people in NAMI and feel I am alone. You will have to work hard to develop any credibility with me at this point.

Agenda Item 14: Where do we go from here?

1. I do not feel like I have completely digested this information. There may be some additional comments I might like to send by email. Is there still time for that?
 - Warren: We are in a very time-sensitive situation. As a result of this meeting I will be coming up with another draft. I want to stay in the loop with workgroup members, who have provided time, energy, and wisdom to help make this as good a process as possible. In terms of further input, we have existing structures for stakeholders to participate in the development process-- the Mental Health Commission, the Consolidated Planning and Advisory Workgroup, the AOD Committee, and the Interagency County on Homelessness. We would like input on whether we work with existing structures for feedback or if we create a new one. We have short deadlines and a few more steps before we meet the Board of Supervisors' requirement to have it on their agenda for June. I can take further input up to the end of this week and anticipate returning a revised draft for review in a week.
2. In the San Francisco approach, the family advocate member of the care team is integral to setting out goals for family involvement in this process, and I am assuming that something similar will be incorporated into this model.
 - Warren: We can make sure this is made clear.
3. Will the revised draft include the comments submitted today? Also, is there is mailing list that you are communicating with people on, and in the interest of transparency, can we get copies of the comments that people submit?
 - Yes. There will be a revised draft, and then we will communicate what people have submitted.
 - Are there areas that don't need to be submitted to the Board immediately, such as perhaps details of the evaluation design as opposed to the main program design and job descriptions? Could you differentiate between what feedback you would need immediately before presenting the program draft to the Board and what things people might still have time to give you feedback on a longer time frame, such as over the

summer?

- Warren: This is why we have Appendix D for details that will still need to be fleshed out. The one-page overview is the nuts and bolts of the program design. The whole 100-page plan will go to the Board, but it will be encapsulated by County Counsel into a few sentences.
 - So what's going to the Board is not the fine details but just the broader scope, not specifics like how to deal with referred persons who don't want family members involved?
 - Warren: Correct. I believe the program draft will be a discussion item.
 - The directive was specifically that the program director should develop stakeholder participation and come back to the Board of Supervisors for final approval at the end of May. Theoretically, it could be a consent item. It is up to the Board if they want to make it a discussion item.
4. What are the workgroup members' advice and input about stakeholder participation regarding the Board making this a consent item or a discussion item until implementation and then throughout implementation?
- Since we have been a big part of this, I suggest that we have periodic gatherings to see where we are at, to watch the progress, and to comment on where we are at and what is happening.
 - In San Francisco, they plan to have a design board group for ongoing implementation oversight and program oversight for at least the first year. I am not sure that existing County structures, such as CPAW, the Mental Health Commission, and AOD, by and in themselves can do the adequate implementation oversight, which I feel is necessary. I see the need for periodic meetings, perhaps twice a month or monthly between now and November.
 - Maybe someone can send out periodic status reports by email, then if a big issue comes up a meeting could be called, as opposed to setting up meetings that may or not may be needed.
 - Can we know as a group when we have hit benchmarks on the timeline? We should also know as a group what County positions have been filled and what positions still need to be filled. There should be a periodic check on whether we have met the timeline on each item, and if not, we need to reconvene.
 - When are the community and stakeholders going to hear about this? Also, what about the different cultures in the community – there are some cultures that keep everything to themselves until death, so we need to reach out to the community and let them know these are services that we provide.
 - How much public oversight do you want with this progress going forward, and what form should it take?
 - Warren: We do have a body, the Mental Health Commission, which has the legislative responsibility for oversight. I could suggest that they put on their agenda how to implement oversight for the program. Participating in the

planning process is different than overseeing the program; those are two different roles. Also, communicating this program to the public and getting public input is another issue.

Workgroup Member Closing Comments

- I would like to thank everybody for participating in this process. It is a lot of information, which means we will have more to think about, and it provokes more questions. I appreciate these questions, because it helps us flesh this out to the best of our ability as we go forward. It will be a work in process as we begin implementation. There will be a lot of changes and conversation. We cannot do it alone. I again want to thank everybody for being here today and for being open and frank about questions and comments, because that is how we will learn as a community.
- I never thought I would see this day, and I am glad to see different representatives from the community here.
- Duane said that the community desires to be involved in this process, and I think that this needs to be fleshed out a little further.
- Regarding the family issues that were brought up here, I think that the family or significant other of the persons referred to the program, or whoever they are living with, need a lot of education so they can be a type of case manager for their loved one. I think that would make it a lot easier on their loved one.
- We are all concerned about the long-term effect of intervention and treatment. There is always a percentage of people who do very well with structure and support, with constant monitoring and supervision, but once they get out of that structure, they have a hard time keeping that structure on themselves and begin to go back into old patterns and endanger themselves. When we look at the intervention and treatment process, we know that we have a lot to learn about that group, as they are the toughest. We design programs around the people they are likely to be effective with, but it is that group of people who is the target population of this program. Being able to keep a connection with the system is really critical, and I wish I had a short-term answer to provide, but it is something we need to consider as we move forward. These individuals are in need of something special, and I don't think we have put our finger quite on it.
- What you are submitting to the Board is something that is more theoretical and foundational and not so specific with regard to implementation and that sort of thing. I would like to specifically focus on how this will affect job classifications. Do we have to create new classifications? Are classifications or job duties changing? I would like to see something very concrete with that. I also want to comment on public safety. Someone commented earlier about a concern about law enforcement officers being present. From the union's perspective, we have seen some violence toward bargaining unit employees by patients or clients of the County. We would like to put forward that we do want law enforcement directly involved, because we rely on them. At the same time, we should look at options that make law enforcement less imposing, such as plain-clothes options or whatever else we can establish.
- I think there is a point where this process will come down to five or six people who are

actually doing the work. I am also concerned about not requiring people to be bilingual or culturally sensitive. I want to emphasize that this is really critical. I also am concerned about what people will have in their hand when they get their contact, if it will be understandable and appropriate.

- I want to thank you for your participation. It has been respectful, honoring, and understanding. There is a lot of work to do. Doug said this will be a three-year gig, and hopefully we will be through 90% of it in three years.

Appendix C – California Welfare and Institutions Code 5345-5349.5

Code: Section: [Up^](#)[Add To My Favorites](#)**WELFARE AND INSTITUTIONS CODE - WIC**

DIVISION 5. COMMUNITY MENTAL HEALTH SERVICES [5000 - 5912] (*Division 5 repealed and added by Stats. 1967, Ch. 1667.*)

PART 1. THE LANTERMAN-PETRIS-SHORT ACT [5000 - 5550] (*Heading of Part 1 amended by Stats. 1968, Ch. 1374.*)

CHAPTER 2. Involuntary Treatment [5150 - 5349.5] (*Chapter 2 added by Stats. 1967, Ch. 1667.*)

ARTICLE 9. The Assisted Outpatient Treatment Demonstration Project Act of 2002 [5345 - 5349.5] (*Article 9 added by Stats. 2002, Ch. 1017, Sec. 2.*)

5345. (a) This article shall be known, and may be cited, as Laura's Law.

(b) "Assisted outpatient treatment" shall be defined as categories of outpatient services that have been ordered by a court pursuant to Section 5346 or 5347.

(*Added by Stats. 2002, Ch. 1017, Sec. 2. Effective January 1, 2003. Repealed as of January 1, 2017, pursuant to Section 5349.5.*)

5346. (a) In any county in which services are available as provided in Section 5348, a court may order a person who is the subject of a petition filed pursuant to this section to obtain assisted outpatient treatment if the court finds, by clear and convincing evidence, that the facts stated in the verified petition filed in accordance with this section are true and establish that all of the requisite criteria set forth in this section are met, including, but not limited to, each of the following:

(1) The person is 18 years of age or older.

(2) The person is suffering from a mental illness as defined in paragraphs (2) and (3) of subdivision (b) of Section 5600.3.

(3) There has been a clinical determination that the person is unlikely to survive safely in the community without supervision.

(4) 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) The person's mental illness has, at least twice within the last 36 months, been a substantial factor in necessitating hospitalization, or receipt of services in a forensic or other mental health unit of a state correctional facility or local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition.

(B) The person's mental illness has resulted in 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, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition.

(5) 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.

(6) The person's condition is substantially deteriorating.

(7) Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure the person's recovery and stability.

(8) 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.

(9) It is likely that the person will benefit from assisted outpatient treatment.

(b) (1) A petition for an order authorizing assisted outpatient treatment may be filed by the county mental health director, or his or her designee, in the superior court in the county in which the person who is the subject of the petition is present or reasonably believed to be present.

(2) A request may be made only by any of the following persons to the county mental health department for the filing of a petition to obtain an order authorizing assisted outpatient treatment:

(A) Any person 18 years of age or older with whom the person who is the subject of the petition resides.

(B) Any person who is the parent, spouse, or sibling or child 18 years of age or older of the person who is the subject of the petition.

(C) The director of any public or private agency, treatment facility, charitable organization, or licensed residential care facility providing mental health services to the person who is the subject of the petition in whose institution the subject of the petition resides.

(D) The director of a hospital in which the person who is the subject of the petition is hospitalized.

(E) A licensed mental health treatment provider who is either supervising the treatment of, or treating for a mental illness, the person who is the subject of the petition.

(F) A peace officer, parole officer, or probation officer assigned to supervise the person who is the subject of the petition.

(3) Upon receiving a request pursuant to paragraph (2), the county mental health director shall conduct an investigation into the appropriateness of the filing of the petition. The director shall file the petition only if he or she determines that there is a reasonable likelihood that all the necessary elements to sustain the petition can be proven in a court of law by clear and convincing evidence.

(4) The petition shall state all of the following:

(A) Each of the criteria for assisted outpatient treatment as set forth in subdivision (a).

(B) Facts that support the petitioner's belief that the person who is the subject of the petition meets each criterion, provided that the hearing on the petition shall be limited to the stated facts in the verified petition, and the petition contains all the grounds on which the petition is based, in order to ensure adequate notice to the person who is the subject of the petition and his or her counsel.

(C) That the person who is the subject of the petition is present, or is reasonably believed to be present, within the county where the petition is filed.

(D) That the person who is the subject of the petition has the right to be represented by counsel in all stages of the proceeding under the petition, in accordance with subdivision (c).

(5) The petition shall be accompanied by an affidavit of a licensed mental health treatment provider designated by the local mental health director who shall state, if applicable, either of the following:

(A) That the licensed mental health treatment provider has personally examined the person who is the subject of the petition no more than 10 days prior to the submission of the petition, the facts and reasons why the person who is the subject of the petition meets the criteria in subdivision (a), that the licensed mental health treatment provider recommends assisted outpatient treatment for the person who is the subject of the petition, and that the licensed mental health treatment provider is willing and able to testify at the hearing on the petition.

(B) That no more than 10 days prior to the filing of the petition, the licensed mental health treatment provider, or his or her designee, has made appropriate attempts to elicit the cooperation of the person who is the subject of the petition, but has not been successful in persuading that person to submit to an examination, that the licensed mental health treatment provider has reason to believe that the person who is the subject of the petition meets the criteria for assisted outpatient treatment, and that the licensed mental health treatment provider is willing and able to examine the person who is the subject of the petition and testify at the hearing on the petition.

(c) The person who is the subject of the petition shall have the right to be represented by counsel at all stages of a proceeding commenced under this section. If the person so elects, the court shall immediately appoint the public defender or other attorney to assist the person in all stages of the proceedings. The person shall pay the cost of the legal services if he or she is able.

(d) (1) Upon receipt by the court of a petition submitted pursuant to subdivision (b), the court shall fix the date for a hearing at a time not later than five days from the date the petition is received by the court, excluding Saturdays, Sundays, and holidays. The petitioner shall promptly cause service of a copy of the petition, together with written notice of the hearing date, to be made personally on the person who is the subject of the petition,

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and shall send a copy of the petition and notice to the county office of patient rights, and to the current health care provider appointed for the person who is the subject of the petition, if any such provider is known to the petitioner. Continuances shall be permitted only for good cause shown. In granting continuances, the court shall consider the need for further examination by a physician or the potential need to provide expeditiously assisted outpatient treatment. Upon the hearing date, or upon any other date or dates to which the proceeding may be continued, the court shall hear testimony. If it is deemed advisable by the court, and if the person who is the subject of the petition is available and has received notice pursuant to this section, the court may examine in or out of court the person who is the subject of the petition who is alleged to be in need of assisted outpatient treatment. If the person who is the subject of the petition does not appear at the hearing, and appropriate attempts to elicit the attendance of the person have failed, the court may conduct the hearing in the person's absence. If the hearing is conducted without the person present, the court shall set forth the factual basis for conducting the hearing without the person's presence.

(2) The court shall not order assisted outpatient treatment unless an examining licensed mental health treatment provider, who has personally examined, and has reviewed the available treatment history of, the person who is the subject of the petition within the time period commencing 10 days before the filing of the petition, testifies in person at the hearing.

(3) If the person who is the subject of the petition has refused to be examined by a licensed mental health treatment provider, the court may request that the person consent to an examination by a licensed mental health treatment provider appointed by the court. If the person who is the subject of the petition does not consent and the court finds reasonable cause to believe that the allegations in the petition are true, the court may order any person designated under Section 5150 to take into custody the person who is the subject of the petition and transport him or her, or cause him or her to be transported, to a hospital for examination by a licensed mental health treatment provider as soon as is practicable. Detention of the person who is the subject of the petition under the order may not exceed 72 hours. If the examination is performed by another licensed mental health treatment provider, the examining licensed mental health treatment provider may consult with the licensed mental health treatment provider whose affirmation or affidavit accompanied the petition regarding the issues of whether the allegations in the petition are true and whether the person meets the criteria for assisted outpatient treatment.

(4) The person who is the subject of the petition shall have all of the following rights:

(A) To adequate notice of the hearings to the person who is the subject of the petition, as well as to parties designated by the person who is the subject of the petition.

(B) To receive a copy of the court-ordered evaluation.

(C) To counsel. If the person has not retained counsel, the court shall appoint a public defender.

(D) To be informed of his or her right to judicial review by habeas corpus.

(E) To be present at the hearing unless he or she waives the right to be present.

(F) To present evidence.

(G) To call witnesses on his or her behalf.

(H) To cross-examine witnesses.

(I) To appeal decisions, and to be informed of his or her right to appeal.

(5) (A) If after hearing all relevant evidence, the court finds that the person who is the subject of the petition does not meet the criteria for assisted outpatient treatment, the court shall dismiss the petition.

(B) If after hearing all relevant evidence, the court finds that the person who is the subject of the petition meets the criteria for assisted outpatient treatment, and there is no appropriate and feasible less restrictive alternative, the court may order the person who is the subject of the petition to receive assisted outpatient treatment for an initial period not to exceed six months. In fashioning the order, the court shall specify that the proposed treatment is the least restrictive treatment appropriate and feasible for the person who is the subject of the petition. The order shall state the categories of assisted outpatient treatment, as set forth in Section 5348, that the person who is the subject of the petition is to receive, and the court may not order treatment that has not been recommended by the examining licensed mental health treatment provider and included in the written treatment plan for assisted outpatient treatment as required by subdivision (e). If the person has executed an advance health care directive pursuant to Chapter 2 (commencing with Section 4650) of Part 1 of Division 4.7 of the Probate Code, any directions included in the advance health care directive shall be considered in formulating the written treatment plan.

(6) If the person who is the subject of a petition for an order for assisted outpatient treatment pursuant to subparagraph (B) of paragraph (5) of subdivision (d) refuses to participate in the assisted outpatient treatment program, the court may order the person to meet with the assisted outpatient treatment team designated by the director of the assisted outpatient treatment program. The treatment team shall attempt to gain the person's cooperation with treatment ordered by the court. The person may be subject to a 72-hour hold pursuant to subdivision (f) only after the treatment team has attempted to gain the person's cooperation with treatment ordered by the court, and has been unable to do so.

(e) Assisted outpatient treatment shall not be ordered unless the licensed mental health treatment provider recommending assisted outpatient treatment to the court has submitted to the court a written treatment plan that includes services as set forth in Section 5348, and the court finds, in consultation with the county mental health director, or his or her designee, all of the following:

(1) That the services are available from the county, or a provider approved by the county, for the duration of the court order.

(2) That the services have been offered to the person by the local director of mental health, or his or her designee, and the person has been given an opportunity to participate on a voluntary basis, and the person has failed to engage in, or has refused, treatment.

(3) That all of the elements of the petition required by this article have been met.

(4) That the treatment plan will be delivered to the county director of mental health, or to his or her appropriate designee.

(f) If, in the clinical judgment of a licensed mental health treatment provider, the person who is the subject of the petition has failed or has refused to comply with the treatment ordered by the court, and, in the clinical judgment of the licensed mental health treatment provider, efforts were made to solicit compliance, and, in the clinical judgment of the licensed mental health treatment provider, the person may be in need of involuntary admission to a hospital for evaluation, the provider may request that persons designated under Section 5150 take into custody the person who is the subject of the petition and transport him or her, or cause him or her to be transported, to a hospital, to be held up to 72 hours for examination by a licensed mental health treatment provider to determine if the person is in need of treatment pursuant to Section 5150. Any continued involuntary retention in a hospital beyond the initial 72-hour period shall be pursuant to Section 5150. If at any time during the 72-hour period the person is determined not to meet the criteria of Section 5150, and does not agree to stay in the hospital as a voluntary patient, he or she shall be released and any subsequent involuntary detention in a hospital shall be pursuant to Section 5150. Failure to comply with an order of assisted outpatient treatment alone may not be grounds for involuntary civil commitment or a finding that the person who is the subject of the petition is in contempt of court.

(g) If the director of the assisted outpatient treatment program determines that the condition of the patient requires further assisted outpatient treatment, the director shall apply to the court, prior to the expiration of the period of the initial assisted outpatient treatment order, for an order authorizing continued assisted outpatient treatment for a period not to exceed 180 days from the date of the order. The procedures for obtaining any order pursuant to this subdivision shall be in accordance with subdivisions (a) to (f), inclusive. The period for further involuntary outpatient treatment authorized by any subsequent order under this subdivision may not exceed 180 days from the date of the order.

(h) At intervals of not less than 60 days during an assisted outpatient treatment order, the director of the outpatient treatment program shall file an affidavit with the court that ordered the outpatient treatment affirming that the person who is the subject of the order continues to meet the criteria for assisted outpatient treatment. At these times, the person who is the subject of the order shall have the right to a hearing on whether or not he or she still meets the criteria for assisted outpatient treatment if he or she disagrees with the director's affidavit. The burden of proof shall be on the director.

(i) During each 60-day period specified in subdivision (h), if the person who is the subject of the order believes that he or she is being wrongfully retained in the assisted outpatient treatment program against his or her wishes, he or she may file a petition for a writ of habeas corpus, thus requiring the director of the assisted outpatient treatment program to prove that the person who is the subject of the order continues to meet the criteria for assisted outpatient treatment.

(j) Any person ordered to undergo assisted outpatient treatment pursuant to this article, who was not present at the hearing at which the order was issued, may immediately petition the court for a writ of habeas corpus. Treatment under the order for assisted outpatient treatment may not commence until the resolution of that petition.

(Amended by Stats. 2003, Ch. 62, Sec. 326. Effective January 1, 2004. Repealed as of January 1, 2017, pursuant to Section 5349.5.)

5347. (a) In any county in which services are available pursuant to Section 5348, any person who is determined by the court to be subject to subdivision (a) of Section 5346 may voluntarily enter into an agreement for services under this section.

(b) (1) After a petition for an order for assisted outpatient treatment is filed, but before the conclusion of the hearing on the petition, the person who is the subject of the petition, or the person's legal counsel with the person's consent, may waive the right to an assisted outpatient treatment hearing for the purpose of obtaining treatment under a settlement agreement, provided that an examining licensed mental health treatment provider states that the person can survive safely in the community. The settlement agreement may not exceed 180 days in duration and shall be agreed to by all parties.

(2) The settlement agreement shall be in writing, shall be approved by the court, and shall include a treatment plan developed by the community-based program that will provide services that provide treatment in the least restrictive manner consistent with the needs of the person who is the subject of the petition.

(3) Either party may request that the court modify the treatment plan at any time during the 180-day period.

(4) The court shall designate the appropriate county department to monitor the person's treatment under, and compliance with, the settlement agreement. If the person fails to comply with the treatment according to the agreement, the designated county department shall notify the counsel designated by the county and the person's counsel of the person's noncompliance.

(5) A settlement agreement approved by the court pursuant to this section shall have the same force and effect as an order for assisted outpatient treatment pursuant to Section 5346.

(6) At a hearing on the issue of noncompliance with the agreement, the written statement of noncompliance submitted shall be prima facie evidence that a violation of the conditions of the agreement has occurred. If the person who is the subject of the petition denies any of the facts as stated in the statement, he or she has the burden of proving by a preponderance of the evidence that the alleged facts are false.

(Added by Stats. 2002, Ch. 1017, Sec. 2. Effective January 1, 2003. Repealed as of January 1, 2017, pursuant to Section 5349.5.)

5348. (a) For purposes of subdivision (e) of Section 5346, a county that chooses to provide assisted outpatient treatment services pursuant to this article shall offer assisted outpatient treatment services including, but not limited to, all of the following:

(1) Community-based, mobile, multidisciplinary, highly trained mental health teams that use high staff-to-client ratios of no more than 10 clients per team member for those subject to court-ordered services pursuant to Section 5346.

(2) A service planning and delivery process that includes the following:

(A) Determination of the numbers of persons to be served and the programs and services that will be provided to meet their needs. The local director of mental health shall consult with the sheriff, the police chief, the probation officer, the mental health board, contract agencies, and family, client, ethnic, and citizen constituency groups as determined by the director.

(B) Plans for services, including outreach to families whose severely mentally ill adult is living with them, design of mental health services, coordination and access to medications, psychiatric and psychological services, substance abuse services, supportive housing or other housing assistance, vocational rehabilitation, and veterans' services. Plans shall also contain evaluation strategies, which shall consider cultural, linguistic, gender, age, and special needs of minorities and those based on any characteristic listed or defined in Section 11135 of the Government Code in the target populations. Provision shall be made for staff with the cultural background and linguistic skills necessary to remove barriers to mental health services as a result of having limited-English-speaking ability and cultural differences. Recipients of outreach services may include families, the public, primary care physicians, and others who are likely to come into contact with individuals who may be suffering from an untreated severe mental illness who would be likely to become homeless if the illness continued to be untreated for a substantial period of time. Outreach to adults may include adults voluntarily or involuntarily hospitalized as a result of a severe mental illness.

(C) Provision for services to meet the needs of persons who are physically disabled.

(D) Provision for services to meet the special needs of older adults.

(E) Provision for family support and consultation services, parenting support and consultation services, and peer support or self-help group support, where appropriate.

(F) Provision for services to be client-directed and that employ psychosocial rehabilitation and recovery principles.

(G) Provision for psychiatric and psychological services that are integrated with other services and for psychiatric and psychological collaboration in overall service planning.

(H) Provision for services specifically directed to seriously mentally ill young adults 25 years of age or younger who are homeless or at significant risk of becoming homeless. These provisions may include continuation of services that still would be received through other funds had eligibility not been terminated as a result of age.

(I) Services reflecting special needs of women from diverse cultural backgrounds, including supportive housing that accepts children, personal services coordinator therapeutic treatment, and substance treatment programs that address gender-specific trauma and abuse in the lives of persons with mental illness, and vocational rehabilitation programs that offer job training programs free of gender bias and sensitive to the needs of women.

(J) Provision for housing for clients that is immediate, transitional, permanent, or all of these.

(K) Provision for clients who have been suffering from an untreated severe mental illness for less than one year, and who do not require the full range of services, but are at risk of becoming homeless unless a comprehensive individual and family support services plan is implemented. These clients shall be served in a manner that is designed to meet their needs.

(3) Each client shall have a clearly designated mental health personal services coordinator who may be part of a multidisciplinary treatment team who is responsible for providing or assuring needed services. Responsibilities include complete assessment of the client's needs, development of the client's personal services plan, linkage with all appropriate community services, monitoring of the quality and followthrough of services, and necessary advocacy to ensure each client receives those services that are agreed to in the personal services plan. Each client shall participate in the development of his or her personal services plan, and responsible staff shall consult with the designated conservator, if one has been appointed, and, with the consent of the client, shall consult with the family and other significant persons as appropriate.

(4) The individual personal services plan shall ensure that persons subject to assisted outpatient treatment programs receive age-appropriate, gender-appropriate, and culturally appropriate services, to the extent feasible, that are designed to enable recipients to:

(A) Live in the most independent, least restrictive housing feasible in the local community, and, for clients with children, to live in a supportive housing environment that strives for reunification with their children or assists clients in maintaining custody of their children as is appropriate.

(B) Engage in the highest level of work or productive activity appropriate to their abilities and experience.

(C) Create and maintain a support system consisting of friends, family, and participation in community activities.

(D) Access an appropriate level of academic education or vocational training.

(E) Obtain an adequate income.

(F) Self-manage their illnesses and exert as much control as possible over both the day-to-day and long-term decisions that affect their lives.

(G) Access necessary physical health care and maintain the best possible physical health.

(H) Reduce or eliminate serious antisocial or criminal behavior, and thereby reduce or eliminate their contact with the criminal justice system.

(I) Reduce or eliminate the distress caused by the symptoms of mental illness.

(J) Have freedom from dangerous addictive substances.

(5) The individual personal services plan shall describe the service array that meets the requirements of paragraph (4), and to the extent applicable to the individual, the requirements of paragraph (2).

(b) A county that provides assisted outpatient treatment services pursuant to this article also shall offer the same services on a voluntary basis.

(c) Involuntary medication shall not be allowed absent a separate order by the court pursuant to Sections 5332 to 5336, inclusive.

(d) A county that operates an assisted outpatient treatment program pursuant to this article shall provide data to the State Department of Health Care Services and, based on the data, the department shall report to the

Legislature on or before May 1 of each year in which the county provides services pursuant to this article. The report shall include, at a minimum, an evaluation of the effectiveness of the strategies employed by each program operated pursuant to this article in reducing homelessness and hospitalization of persons in the program and in reducing involvement with local law enforcement by persons in the program. The evaluation and report shall also include any other measures identified by the department regarding persons in the program and all of the following, based on information that is available:

- (1) The number of persons served by the program and, of those, the number who are able to maintain housing and the number who maintain contact with the treatment system.
- (2) The number of persons in the program with contacts with local law enforcement, and the extent to which local and state incarceration of persons in the program has been reduced or avoided.
- (3) The number of persons in the program participating in employment services programs, including competitive employment.
- (4) The days of hospitalization of persons in the program that have been reduced or avoided.
- (5) Adherence to prescribed treatment by persons in the program.
- (6) Other indicators of successful engagement, if any, by persons in the program.
- (7) Victimization of persons in the program.
- (8) Violent behavior of persons in the program.
- (9) Substance abuse by persons in the program.
- (10) Type, intensity, and frequency of treatment of persons in the program.
- (11) Extent to which enforcement mechanisms are used by the program, when applicable.
- (12) Social functioning of persons in the program.
- (13) Skills in independent living of persons in the program.
- (14) Satisfaction with program services both by those receiving them and by their families, when relevant.

(Amended by Stats. 2012, Ch. 34, Sec. 95. Effective June 27, 2012. Repealed as of January 1, 2017, pursuant to Section 5349.5.)

5349. This article shall be operative in those counties in which the county board of supervisors, by resolution or through the county budget process, authorizes its application and makes a finding that no voluntary mental health program serving adults, and no children's mental health program, may be reduced as a result of the implementation of this article. To the extent otherwise permitted under state and federal law, counties that elect to implement this article may pay for the provision of services under Sections 5347 and 5348 using funds distributed to the counties from the Mental Health Subaccount, the Mental Health Equity Subaccount, and the Vehicle License Collection Account of the Local Revenue Fund, funds from the Mental Health Account and the Behavioral Health Subaccount within the Support Services Account of the Local Revenue Fund 2011, funds from the Mental Health Services Fund when included in county plans pursuant to Section 5847, and any other funds from which the Controller makes distributions to the counties for those purposes. Compliance with this section shall be monitored by the State Department of Health Care Services as part of its review and approval of county performance contracts.

(Amended by Stats. 2013, Ch. 288, Sec. 2. Effective January 1, 2014. Repealed as of January 1, 2017, pursuant to Section 5349.5.)

5349.1. (a) Counties that elect to implement this article, shall, in consultation with the State Department of Health Care Services, client and family advocacy organizations, and other stakeholders, develop a training and education program for purposes of improving the delivery of services to mentally ill individuals who are, or who are at risk of being, involuntarily committed under this part. This training shall be provided to mental health treatment providers contracting with participating counties and to other individuals, including, but not limited to, mental health professionals, law enforcement officials, and certification hearing officers involved in making treatment and involuntary commitment decisions.

(b) The training shall include both of the following:

- (1) Information relative to legal requirements for detaining a person for involuntary inpatient and outpatient treatment, including criteria to be considered with respect to determining if a person is considered to be gravely disabled.

(2) Methods for ensuring that decisions regarding involuntary treatment as provided for in this part direct patients toward the most effective treatment. Training shall include an emphasis on each patient's right to provide informed consent to assistance.

(Amended by Stats. 2012, Ch. 34, Sec. 97. Effective June 27, 2012. Repealed as of January 1, 2017, pursuant to Section 5349.5.)

5349.5. (a) This article shall remain in effect only until January 1, 2017, and as of that date is repealed, unless a later enacted statute that is enacted on or before January 1, 2017, deletes or extends that date.

(b) The State Department of Health Care Services shall submit a report and evaluation of all counties implementing any component of this article to the Governor and to the Legislature by July 1, 2015. The evaluation shall include data described in subdivision (d) of Section 5348.

(Amended by Stats. 2012, Ch. 441, Sec. 1. Effective January 1, 2013. Repealed as of January 1, 2017, by its own provisions. Note: Repeal affects Article 9, commencing with Section 5345.)

Appendix D – Issues for Resolution

The following issues have been surfaced in the planning of this program design. Contra Costa County staff will continue to work to resolve these issues prior to and during program implementation.

Legal.

1. Is the investigation process subject to HIPAA? Does the mental health clinician have access without informed consent to medical information pertaining to the subject of a Request for Petition by a Qualified Requesting Party?
2. What information is required to be shared with the Qualified Requesting Party about the court process?
3. How will civil standby protocol be developed and communicated to law enforcement agencies outside the jurisdiction of the County Sheriff's Office?
4. How will the AOT process interface with veterans and the Veterans Administration?

Program.

1. Is there an appeals process by a Qualified Requesting Party when the mental health clinician decides not to file a Court Petition, or recommends dismissal when a client is not benefitting from court ordered treatment due to persistent non-compliance?
2. What are the conditions and protocol for requesting law enforcement to be present and act as civil standby when it is determined to be unsafe for the investigating mental health clinician or treatment provider? What is procedure when law enforcement is unable to provide a civil standby?
3. Who will serve the summons to a Court Hearing to the subject of a petition?
4. What is the process for determining what direct services are to be provided by the ACT Team, and what services are to be provided by other service providers; how is this full spectrum of services coordinated, and who decides which service provider has the lead for a particular service delivery?

Communication. The scope and budget of community education efforts with accompanying costs will need to be identified and quantified.

Evaluation. The contract fair market value for establishing the cost for completing the evaluation will need to be determined.

Budget. In addition to the above budget issues the program design will need to develop a means to quantify the County's ongoing fiscal obligation that is incurred by

providing supported housing to those individuals who improve by virtue of AOT intervention and move to lower levels of mental health care. These are costs over and above that which is included in the ACT Team's budget.

Appendix E – Screening, Intervention, Investigation Protocol

The following protocol will be utilized as a guide for compliance with WIC Section 5346.

1. Screening

- A request for an AOT petition will be communicated to the Care Team.
- The Care Team will verify that the requesting party is a “Qualified Requesting Party”.
 - If a party requesting AOT assessment is not a Qualified Requesting Party, the Care Team will assist in connecting the party to more appropriate services.
 - If the party is a Qualified Requesting Party the Care Team will begin to engage the referred individual and conduct an investigation to determine eligibility.

2. Intervention

- The Care Team will respond within five business days with an initial intervention, and offer appropriate voluntary services to the referred individual, to include explanation of Patient’s Rights.
- The Care Team will attempt to engage the referred individual in voluntary services for up to three contacts per week, for a period up to 30 days. However, a petition may be filed prior to 30 days if further deterioration is documented.
- The county employed licensed clinician, as Care Team Lead, can authorize additional outreach and engagement time and effort beyond 30 days, as appropriate.
- The Care Team contacts the Qualified Requesting Party with their recommendations as to whether the referred individual will receive AOT services.
- Should a referred individual be currently enrolled in a treatment program, the Care Team will determine whether all outreach and engagement efforts from that program have been attempted but not been successful.
- The county employed licensed clinician, as Care Team Lead, can request emergency psychiatric services to ensure the safety of the referred individual, as well as request law enforcement to serve as civil standby, should the Care Team have reason to suspect the referred individual may become violent.
- The county employed licensed clinician, as Care Team Lead, may begin the investigation process, should the referred individual refuse the services offered, either initially or within six months of agreeing to any service offered as part of the intervention process.

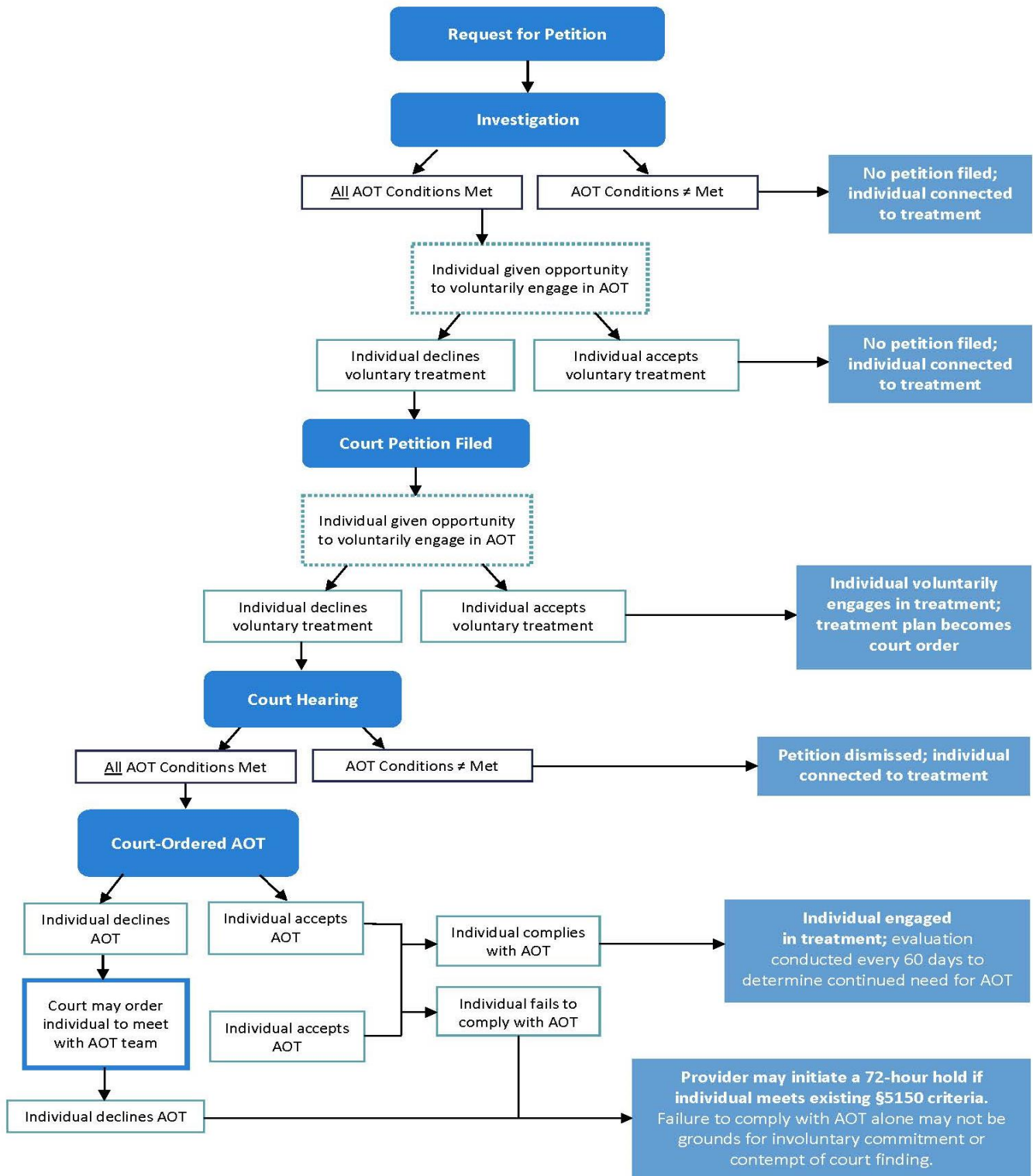
3. Investigation

- The CCBHS Team, which includes the county employed licensed clinician acting as Care Team Lead, will be responsible for implementing the Investigation protocol, and will be done concurrently with the Screening and Intervention protocol.
- The contract provider ACT Team members who are part of the Care Team (usually family partner and peer provider) assist the CCBHS Team in this investigative protocol by working with the referred individual, the Qualified Requesting Party, and all other significant individuals in the referred individual's life to gather the necessary information to determine whether AOT criteria are present.
- Staff involved in the Investigation follow all applicable provisions of federal and state privacy laws.
- The following information is utilized during the Investigation:
 - Available health and hospitalization records
 - Available mental health history
 - Available incarceration history and mental health treatment during incarceration
 - Current living situation
- The AOT Eligibility Checklist will be completed to determine whether the referred individual meets each AOT criteria.
- Once it is determined the referred individual is an appropriate candidate for treatment services, the CCBHS Team will attempt to collaboratively develop with the ACT Team and the referred individual a treatment plan, to include an assessment and mental status examination.
- The CCBHS Team will authorize the ACT Team to provide services if the referred individual, now considered a "client", consents to the assessment and treatment plan.

If the client does not consent to the assessment and/or treatment plan, the CCBHS Team will refer the matter to County Counsel to determine whether a petition should be filed with the court.

Appendix F – Legal Process Flow Chart

Overview of Assisted Outpatient Treatment (AOT) Process • [W&I 5345-5349.5](#)



¹ Courtesy of Jo Robinson, Director of Community Behavioral Health Services, City and County of San Francisco.

Appendix G – Request for Petition

A Request for Petition may be made only by any of the following persons, or Qualified Requesting Party, to the CCBHS Team in order to request that the Behavioral Health Director, or his/her designee, file a Court Petition on behalf of an individual who they consider eligible for Assisted Outpatient Treatment:

- Any person 18 years of age or older with whom the person who is the subject of the petition resides.
- Any person who is the parent, spouse, or sibling or child 18 years of age or older of the person who is the subject of the petition.
- The director of any public or private agency, treatment facility, charitable organization, or licensed residential care facility providing mental health services to the person who is the subject of the petition in whose institution the subject of the petition resides.
- The director of a hospital in which the person who is the subject of the petition is hospitalized.
- A licensed mental health treatment provider who is either supervising the treatment of, or treating for a mental illness, the person who is the subject of the petition.
- A peace officer, parole officer, or probation officer assigned to supervise the person who is the subject of a petition.

A Request for Petition is a written statement by a Qualified Requesting Party that addresses how the individual qualifies as a Qualified Requesting Party, and the basis for which they believe the subject of a Request for Petition may qualify for AOT.

Appendix H - AOT Eligibility Checklist specifies all of the eligibility requirements that the CCBHS licensed mental health clinician must verify as part of their investigatory process before a Court Petition can be filed. A Qualifying Requesting Party can assist with this investigatory process by providing information to the best of their knowledge on the following areas regarding the subject of the request. Is the person:

- 18 years of age or older
- Suffering from a mental health issue, and is substantially deteriorating
- Unlikely to survive safely in the community without supervision
- Have a history of lack of compliance with his/her treatment
- Been hospitalized or incarcerated primarily due to a mental illness
- Attempted or committed one or more acts of serious and violent behavior to him/herself or to others

The CCBHS Team mental health clinician will then initiate an investigation, culminating in completion of the AOT Eligibility Checklist.

Appendix H – AOT Eligibility Checklist

The CCBHS Team mental health clinician is responsible for completing an investigation in order to determine whether the subject of a Request for Petition meets eligibility for AOT. The AOT Eligibility Checklist is the signed verification that clear and convincing evidence are established that **all** of the following requisite criteria for eligibility are met. The checklist will contain evidence and comments verifying that:

- The person has been referred by a Qualified Requesting Party.
- The person is believed to be a resident of Contra Costa County
- Is 18 years or older.
- Has a serious mental illness as defined by WIC Section 5600.3, paragraphs (2) and (3) of subdivision (b).
- 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:
 - The person's mental illness has, at least twice within the last 36 months, been a substantial factor in necessitating hospitalization, or receipt of services in a forensic or other mental health unit of a state or local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition.
 - The person's mental illness has resulted in one or more acts of serious and violent behavior toward him/herself or another, or threats or attempts to cause serious physical harm to him/herself or another within the last 48 months, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition.
- The person has been offered an opportunity to participate in a treatment plan that includes all of the services described in WIC Section 5348, and the person continues to fail to engage in treatment.
- The person's condition is substantially deteriorating.
- Participation in the AOT 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 likely result in grave disability or serious harm to him/herself, or to others as defined in WIC Section 5150.

Appendix I – Court Petition

The CCBHS Team mental health clinician notifies County Counsel in writing of the intent to file a Court Petition within ten (10) days of the examination, or attempted examination of the subject of a Court Petition. After County Counsel's review the Contra Costa Behavioral Health Services Director signs the Court Petition. The Court Petition will have three attachments; the Declaration, a recommended treatment plan, and the AOT Eligibility Checklist. The Court Petition contains the following:

- Verification of the credentials of the licensed mental health clinician making the petition, and ability and capacity to testify,
- Statements to verify subject's eligibility for AOT,
- Evidence to support treatment attempts and subject's resistance to participation.

Accompanying the Petition will be a Notice of Hearing.

Appendix J – Notice of Hearing

When a Court Petition is filed the court will set a hearing date and time no later than five (5) court days from the time the Court Petition is filed, and assign a Public Defender. The Court Petition and Notice of Hearing are personally served on the subject of the Court Petition, as well as copies sent or delivered to the Public Defender, the Patient Rights Advocate, any current health care provider, and any persons designated by the subject of a Court Petition. Those persons receiving the Court Petition will be in a position to contact and advise the subject of the Court Petition, assist in the subject exercising their legal rights and make a timely appearance at the hearing.

The Notice of Hearing will list the subject's legal rights as per WIC Section 5346(d)4:

- To adequate notice of the hearings to the person who is the subject of the petition, as well as to parties designated by the person who is the subject of the petition.
- To receive a copy of the court-ordered evaluation.
- To counsel. If the person has not retained counsel, the court shall appoint a public defender.
- To be informed of his or her right to judicial review by habeas corpus.
- To be present at the hearing unless he or she waives the right to be present.
- To provide evidence.
- To call witnesses on his or her behalf.
- To cross-examine witnesses.
- To appeal decisions, sand to be informed of his or her right to appeal.

The Notice of Hearing will provide contact information of the Public Defender and the author of the Court Petition, as well as proof that the Notice of Hearing has been served.

