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

Introduction

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

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

Stakeholder Communications

Pre-Enrollment

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

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

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

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

RDA response:

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

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

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

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

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

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

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

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

AOT Enrollment

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

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

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

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

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

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

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

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

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

ACT Fidelity Assessment

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

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

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

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

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

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

Consumer Outcomes

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

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

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

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

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

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

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

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

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

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

Cost

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

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

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

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

When will the program reach 75 person capacity?

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