FAMILY & HUMAN SERVICES COMMITTEE

September 25, 2017
10:30 A.M.
651 Pine Street, Room 101, Martinez

Agenda

Supervisor John Gioia, Chair
Supervisor Candace Andersen, Vice Chair

Agenda Items:	Items may be taken out of order based on the business of the day and preference of the Committee

1. Introductions

2. Public comment on any item under the jurisdiction of the Committee and not on this agenda (speakers may be limited to three minutes).

3. RECOMMEND to the Board of Supervisors the appointment of G.Vittoria Abbate to the Adult Education & Literacy #1 seat on the Workforce Development Board with a term expiring June 30, 2020, as recommended by the Workforce Development Board.

4. CONSIDER accepting the Assisted Outpatient Treatment evaluation reports for fiscal year 2016-17 as provided by the Health Services Department and Resource Development Associates and forwarding the attached reports to the Board of Supervisors for their information. (Warren Hayes, MHSA Program Manager)

5. CONSIDER accepting the report from the Employment and Human Services Department on the foster care Continuum of Care Reform implementation efforts and forwarding it to the Board of Supervisors for their information. (Kathy Gallagher, Employment and Human Services Director)

6. The next meeting is currently scheduled for November 6, 2017 at 9:00 am.

7. Adjourn

The Family & Human Services Committee will provide reasonable accommodations for persons with disabilities planning to attend Family & Human Services Committee meetings. Contact the staff person listed below at least 72 hours before the meeting.

Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the County to a majority of members of the Family & Human Services Committee less than 96 hours prior to that meeting are available for public inspection at 651 Pine Street, 10th floor, during normal business hours.

Public comment may be submitted via electronic mail on agenda items at least one full work day prior to the published meeting time.

For Additional Information Contact:

Enid Mendoza, Committee Staff
Phone (925) 335-1039, Fax (925) 646-1353
enid.mendoza@cao.cccounty.us

Contra Costa County Board of Supervisors

Subcommittee Report

FAMILY AND HUMAN SERVICES COMMITTEE **3.**

Meeting Date: 09/25/2017

Subject: Appointments to the Workforce Development Board

Submitted For: FAMILY & HUMAN SERVICES COMMITTEE,

Department: County Administrator

Referral No.: N/A

Referral Name: Appointments to Advisory Bodies

Presenter: N/A **Contact:** Enid Mendoza, (925) 335-1039

Referral History:

On December 13, 2011, The Board of Supervisors adopted Resolution No. 2011/498 adopting policy governing appointments to independent boards, committees, and commissions, and special districts. Included in this resolution was a requirement that independent bodies initially conducting interviews for At Large/Countywide seats provide appointment recommendations to a Board Committee for further review.

The Workforce Development Board implements federal requirements for programs to address the education, skills, and employment needs for a skilled workforce, and that lead to an increase in the skills and earnings of Contra Costa residents.

On March 14, 2016, the Family and Human Services Committee (F&HS) accepted the Employment and Human Services Department's recommendation to decertify the then current Workforce Investment Act local Board and recertify a new board structure in compliance with the new Workforce Innovation and Opportunity Act (WIOA). F&HS approved these recommendations, and the Board did the same at their March 29, 2016 meeting.

Under new standards in WIOA (2016) and as adopted by the Board on March 29, 2016, the new Workforce Development Board structure is: a total of 23 required seats and 2 "optional seats", consisting of: 13 Business representatives, 5 Workforce representatives, and 5 Education and Training representatives as follows: (1) Adult Education/Literacy; (2) Higher Education; (3) Economic & Community Devl; (4) Wagner Peyser representative; (5) Vocational Rehabilitation. Also two additional/ "optional" seats that may be filled from any of the 3 categories above.

Referral Update:

The Workforce Development Board currently has 19 filled seats and 13 vacancies. Below is the current roster:

Seat Title	Term Expiration Date	Current Incumbent	Incumbent Supervisor District	BOS Appointment Date	Number of Meetings Attended Since Appointment Date	Total Number of Meeting Since Appointment (Full Board)	Total Number of Absences Allowable in By-laws
Business 1	6/30/2020	McGill Michael	II	3/29/2016	5	5	0
Business 2	6/30/2020	VACANT					
Business 2	6/30/2020	VACANT					
Business 3	6/30/2020	VACANT					
Business 3	6/30/2020	Mahoney, William	V	5/23/2017	0	0	0
Business 4	6/30/2020	Carrillo Maggie	III	3/29/2016	2	5	3
Business 5	6/30/2020	Amin Bhuphen B.	IV	3/29/2016	5	5	0
Business 6	6/30/2020	Carrascal Jose	III	3/29/2016	4	5	1

Business 7	6/30/2020	Cox Jason	IV	3/29/2016	4	5	1
Business 8	6/30/2020	Georgian Ashley	II	3/29/2016	4	5	1
Business 9	6/30/2020	VACANT					
Business 9	6/30/2020	Robert Lilley	V	7/11/2017	0	0	0
Business 10	6/30/2020	Rivera Robert	IV	3/29/2016	5	5	0
Business 11	6/30/2020	Steele Justin	I	3/29/2016	5	5	0
Business 12	6/30/2020	Adler Paul	V	3/29/2016	3	5	2
Business 13	6/30/2020	VACANT					
Workforce Representative 1	6/30/2020	VACANT					
Workforce Representative 1	6/30/2020	VACANT					
Workforce Representative 2	6/30/2020	Williams III Robert	I	3/29/2016	4	5	1
Workforce Representative 3	6/30/2020	Older Steve	IV	3/29/2016	5	5	0
Workforce Representative 4	6/30/2020	Hanlon Margaret	I	3/29/2016	4	5	1
Workforce Representative 5	6/30/2020	VACANT					
Workforce Representative 5	6/30/2020	VACANT					
Education 1: Adult Ed/Literacy	6/30/2020	VACANT					
Education 1: Adult Ed/Literacy	6/30/2020	VACANT					
Education 2: Higher Education	6/30/2020	VACANT					
Education 2: Higher Education	6/30/2020	VACANT					
Education 3: Economic/Community Dev.	6/30/2020	Connelly Kristin	II	3/29/2016	4	5	1
Education 4: Employment Development	6/30/2020	Johnson Richard	IV	3/29/2016	4	5	1
Additional/Optional #1	6/30/2020	Vega Yolanda	II	3/29/2016	5	5	0
Additional/Optional #2	6/30/2020	Montagh, John	IV	6/6/2017	0	0	0
Education 5: Vocational Rehabilitation	6/30/2020	Asch Carol	IV	3/29/2016	5	5	0

On June 29, 2017, Ms. G.Vittoria Abbate was interviewed for the Adult Education & Literacy #1 seat vacancy and was approved by the Workforce Development Board Executive Committee at their July 12, 2017 meeting. There were no other candidates competing for this seat.

Recommendation(s)/Next Step(s):

RECOMMEND to the Board of Supervisors the appointment of G.Vittoria Abbate to the Adult Education & Literacy #1 seat on the Workforce Development Board with a term expiring June 30, 2020, as recommended by the Workforce Development Board.

Fiscal Impact (if any):

There is no fiscal impact.

Attachments

WDB Memo to F&HS

G.V.Abbate Application

WORKFORCE Development Board Contra Costa County
Building Futures

DONNA VAN WERT
EXECUTIVE DIRECTOR

MEMORANDUM

DATE: July 18, 2017
TO: Family and Human Services Committee
CC: Kevin Corrigan, CAO Senior Management Analyst
Enid Mendoza, CAO Sr. Deputy County Administrator
FROM: Donna Van Wert, Interim Executive Director
SUBJECT: **Appointment to Workforce Development Board**

This memorandum requests the Family and Human Services Committee recommend to the Contra Costa County Board of Supervisors the appointment of the following candidates to the new WIOA compliant Workforce Development Board of Contra Costa County.

Background:

Local board structure and size:

Compared to predecessor legislation, the Workforce Innovation and Opportunity Act (WIOA) substantially changes Local Board composition by reducing local workforce development board size while maintaining a business and industry majority and ensuring representation from labor and employment and training organizations.

The Executive Committee of the local WIOA board met January 21, 2016 and approved a recommended WIOA Board configuration, subsequently approved by the Board of Supervisors on March 29, 2016. To meet the categorical membership percentages, the WDB recommended a board of twenty-five (25) members. This option represents the minimum required local board size under WIOA plus an additional six (6) optional representatives in the following enumerated categories: 1) business; 2) workforce; 3) education and training.

Category – Representatives of Business (WIOA Section 107(b)(2)(A))

- Thirteen (13) representatives (52%)

Category – Representatives of Workforce (WIOA Section 107(b)(2)(A))

- Five (5) representatives (20%)

Category – Representatives of Education and Training (WIOA Section 107(b)(2)(C))

- One (1) Adult Education/Literacy Representative (WIOA title II)
- One (1) Higher Education Representative
- One (1) Economic and Community Development Representative
- One (1) Wagner Peyser Representative
- One (1) Vocational Rehabilitation Representative

Two (2) additional seats from the above categories, including constituencies referenced in Attachment III of Training Employment & Guidance Letter (TEGL) 27-14.

Recommendation:

a) Recommend approval of local board candidate for the vacant Adult Education & Literacy Seat # 1 to the new WIOA-compliant board *(Attached application & board roster)*

- Interview Date – June 29, 2017
- G.Vittoria Abbate - Approved on July 12,2017 at the Executive Committee Meeting
- No other candidate competed for the vacant Adult Education & Literacy Seat # 1

NEW APPOINTMENT

Seat	Last Name	First Name	Address & District #	Term of Expiration	District (Resident)
Adult Education & Literacy Seat #1	Abbate	G.Vittoria	Concord, CA 94519 District#5	6/30/2020	District #2

Thank you

DVW/rms
attachment

Application Form

Profile

This application is used for all boards and commissions

G. Vittoria
First Name

Middle Initial

Abbate
Last Name

vittoriausa@yahoo.com
Email Address

[redacted]
Home Address

Suite or Apt

[redacted]
City

[redacted]
State

[redacted]
Postal Code

[redacted]
Primary Phone

Mt. Diablo Unified School District
Employer

Director, College & Career and Adult Education
Job Title

Director (Administrator)
Occupation

Do you, or a business in which you have a financial interest, have a contract with Contra Costa Co.?

○ Yes ◉ No

Is a member of your family (or step-family) employed by Contra Costa Co.?

○ Yes ◉ No

Interests & Experiences

Which Boards would you like to apply for?

Workforce Development Board: Submitted

Please describe your interest in serving as a member of the board(s) you have selected and if applicable which seat you are applying for.

I am interested in serving as the representative of the eight (8) Adult Education programs in Contra Costa County which include Acalanes Adult Education (Acalanes HSD), Mt. Diablo Adult Education (Mt. Diablo USD), Martinez Adult Education (Martinez USD), Pittsburg Adult Education Center (Pittsburg USD), Liberty Adult Education (Liberty HSD), Antioch Adult Education (Antioch USD), West Contra Costa Adult Education (West Contra Costa USD) and the Contra Costa County Office of Education (CCCOE) Contra Costa Adult School jail ed program in Richmond. Currently I serve as years as the Co-Chair of the state-mandated Contra Costa County Adult Education Consortium (CCCAEC) and previously for four (4) years as President of the Contra Costa Adult Education Network (CCAEN), which recently voted unanimously that I represent them as the Adult Education representative on the Workforce Development Board, replacing Kathy Farwell former DIrector of Martinez Adult Education who served as our representative during the past two years.

Have you previously served on a government or non-profit board or committee?

Yes and as mentioned above, I am currently serving as Co-Chair of the Contra Costa County Adult Education Consortum (CCCAEC) which is a legislatively-authorized and mandated regional Consortium that represents the eight (8) Contra Costa County Adult Education programs, the Contra Costa Community College District Office and its three community colleges (Diablo Valley College, Los Medanos College and Contra Costa College.) In addition, I have served for two years and will continue for two more years as the State Legislative Chair of the California Council for Adult Education (CCAE) which is the primary professional association representing Adult Education in California.

Please describe how your education, work experience, or other activities have prepared you to serve on the board or commission you have selected.

I have more than 35 years of professional training and work in educational administration serving in both private and public education. In particular, my training, background and experience is in the area of international education as well as educational programs serving under-served populations.

Upload a Resume

Education History

Select the highest level of education you have received:

☑ Other

Master's of Arts

If "Other" was Selected Give Highest Grade or Educational Level Achieved

College/ University A

G. Vittoria Abbate

Name of College Attended

in Teaching English to Speakers of Other Langauges)

Course of Study / Major

Master's of Arts Degree

Units Completed

Type of Units Completed

- [ ] Semester
- [ ] Quarter

Degree Awarded?

- (•) Yes
- ( ) No

Teaching English to Speakers of Other Languages)

Degree Type

1975

Date Degree Awarded

College/ University B

California State University (East Bay)

Name of College Attended

Education Administrative Credential

Course of Study / Major

Units Completed

Type of Units Completed

- [ ] Semester
- [ ] Quarter

Degree Awarded?

◉ Yes ○ No

Preliminary & Clear Administrative Services Credential

Degree Type

2006-2007

Date Degree Awarded

College/ University C

Name of College Attended

Course of Study / Major

Units Completed

Type of Units Completed

☐ Semester
☐ Quarter

Degree Awarded?

○ Yes ○ No

Degree Type

Date Degree Awarded

Other schools / training completed:

Course Studied

Hours Completed

Certificate Awarded?

○ Yes ○ No

Work History

Please provide information on your last three positions, including your current one if you are working.

1st (Most Recent)

April 2003 to Present

Dates (Month, Day, Year) From - To

Salaried Employee (60+)

Hours per Week Worked?

Volunteer Work?

◉ Yes ○ No

Position Title

Employer's Name and Address

Duties Performed

2nd

Dates (Month, Day, Year) From - To

Hours per Week Worked?

Volunteer Work?

○ Yes ○ No

Position Title

Employer's Name and Address

Duties Performed

3rd

Dates (Month, Day, Year) From - To

Hours per Week Worked?

Volunteer Work?

○ Yes ○ No

Position Title

Employer's Name and Address

Duties Performed

Final Questions

How did you learn about this vacancy?

☑ Other

representative of Contra Costa County Adult Education programs.

If "Other" was selected please explain

. Do you have a Familial or Financial Relationship with a member of the Board of Supervisors?

Yes No

If Yes, please identify the nature of the relationship:

Do you have any financial relationships with the County such as grants, contracts, or other economic relations?

Yes No

If Yes, please identify the nature of the relationship:

July 5, 2017

Contra Costa County Board of Supervisors
651 Pine Street Room 106
Martinez, CA 94553-1992

RE: Nomination of Vittoria Abbate for Workforce Development Board of Contra Costa

Dear Supervisors John Goia, Candace Anderson, Diane Burgis, Karen Michoff, and Federal Glover:

It is my pleasure to write this letter of support for Vittoria Abbate's application to become a member of the Workforce Development Board of Contra Costa County. Vittoria, as the Director of Adult and College & Career Education for Mt. Diablo Unified School District, is uniquely qualified to represent the needs of adult learners and the critical role of employment and training in changing families' lives for the better.

Mt. Diablo Adult Education has been a long-time key partner to the Workforce Development Board of Contra Costa County and is one of the founding members of the EastbayWORKS Career Centers and One Stop Operator Consortium. Consequently, Vittoria has a strong working knowledge of the WDBCCC and America's Job Centers. Vittoria has been selected by her colleagues across the county to represent Adult Education programs on the WDBCCC. As an experienced adult education administrator, Vittoria has established relationships with numerous business/industry employers and will bring a wealth of knowledge about public/private sector partnerships. She is also a co-chair of the Adult Education/Community Colleges Consortium, which is focused on ensuring pathways for adult learners to higher education and training.

Based on my personal experience working with Vittoria for many years, I can state with confidence that she will take this responsibility seriously as she commits to supporting the work and role of the Workforce Development Board in Contra Costa County. She is broadly respected within Mt. Diablo Unified School District and amongst her colleagues and community partners throughout Contra Costa County and across the state. She was recently recognized as the Association of California School Administrators as the Region VI Adult Education Administrator for 2017.

I sincerely believe that Vittoria's knowledge, experience, integrity, creativity and professionalism will be a tremendous asset to WDBCCC and I encourage your appointment.

Thank you.

[redacted]

Joanne Durkee, Board of Education Trustee
Mt. Diablo Unified School District

Contra Costa County Board of Supervisors

Subcommittee Report

FAMILY AND HUMAN SERVICES COMMITTEE **4.**

Meeting Date: 09/25/2017

Subject: Assisted Outpatient Treatment (Laura's Law) Annual Implementation Update Report

Submitted For: FAMILY & HUMAN SERVICES COMMITTEE,

Department: County Administrator

Referral No.: 107

Referral Name: Laura's Law

Presenter: Warren Hayes, MHSA Program Manager **Contact:** Enid Mendoza, (925) 335-1039

Referral History:

The Assisted Outpatient Treatment Demonstration Project Act (AB 1421), known as Laura's Law, was signed into California law in 2002 and is authorized until January 1, 2017. Laura's Law is named after a 19 year old woman working at a Nevada County mental health clinic. She was one of three individuals who died after a shooting by a psychotic individual who had not engaged in treatment.

AB 1421 allows court-ordered intensive outpatient treatment called Assisted Outpatient Treatment (AOT) for a clearly defined set of individuals that must meet specific criteria. AB 1421 also specifies which individuals may request the County Mental Health Director to file a petition with the superior court for a hearing to determine if the person should be court ordered to receive the services specified under the law. The County Mental Health Director or his licensed designee is required to perform a clinical investigation, and if the request is confirmed, to file a petition to the Court for AOT.

If the court finds that the individual meets the statutory criteria, the recipient will be provided intensive community treatment services and supervision by a multidisciplinary team of mental health professionals with staff-to-client rations of not more that 1 to 10. Treatment is to be client-directed and employ psychosocial rehabilitation and recovery principles. The law specifies various rights of the person who is subject of a Laura's Law petition as well as due process hearing rights.

If a person refuses treatment under AOT, treatment cannot be forced. The Court orders meeting with the treatment team to gain cooperation and can authorize a 72 hour hospitalization to gain cooperation. A Laura's Law petition does not allow for involuntary medication.

AB 1421 requires that a county Board of Supervisors adopt Laura's Law by resolution to authorize the legislation within that county. AB 1421 also requires the Board of Supervisors to make a finding that no voluntary mental health program serving adults or children would be reduced as a result of implementation.

At its June 3, 2013 meeting, the Legislation Committee requested that this matter be referred to the Family and Human Services Committee (F&HS) for consideration of whether to develop a program in the Behavioral Health Division of the Health Services Department that would implement assisted outpatient treatment options here in Contra Costa County.

On July 9, 2013, the Board of Supervisors referred the matter to F&HS for consideration. F&HS received reports on the implementation of Laura's Law on October 16, 2013 and March 10, 2014, and on February 3, 2015 the Board accepted the recommendations to implement Laura's Law. In February 2016, Laura's Law was implemented and the Department provided F&HS with a 6-month implementation report on September 12, 2016 and a data report on the 6-month implementation on December 12, 2016. Both reports were accepted by the Board on September 27, 2016 and December 20, 2016, respectively.

On May 22, 2017 the Family and Human Services Committee received and approved a report on the AOT implementation for the period February through December 2016. The report was later approved by the Board of Supervisors at their July 11, 2017 meeting. The department reported that they would be prepared to provide a full fiscal year report to F&HS and the Board after the July 1, 2016 through June 30, 2017 data was available.

Referral Update:

In partnership with Resource Development Associates (RDA), the Health Services Department Behavioral Health Division has provided the attached reports, which include the AOT Program Evaluation Summary, the Contra Costa County Assisted Outpatient Treatment (AOT) Evaluation for fiscal year 2016/17, and the Contra Costa County Assisted Outpatient Treatment (AOT) Evaluation MHS' ACTiOn Team 2017 Fidelity Assessment.

Recommendation(s)/Next Step(s):

CONSIDER accepting the Assisted Outpatient Treatment evaluation reports for fiscal year 2016-17 as provided by the Health Services Department and Resource Development Associates and forwarding the attached reports to the Board of Supervisors for their information.

Fiscal Impact (if any):

There is no fiscal impact; the report is informational.

Attachments

AOT FY 16-17 Evaluation Summary Report
AOT FY 16-17 Evaluation Report
AOT Evaluation Fidelity Assessment Summary
AOT Evaluation Presentation Slides

Assisted Outpatient Treatment (AOT) Program Evaluation Summary

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

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

Findings.

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

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

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

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

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

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

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

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

Discussion.

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

Recommendations.

1) A significant number of referred individuals are closed due to losing contact. It may be useful to develop training and mechanisms to that would allow Psychiatric Emergency Services, Inpatient Unit 4-C, jail mental health, as well as family members and other significant others to make AOT program staff aware of an AOT-referred individual's presence with enough time available for AOT staff to respond.
2) A number of individuals are taking much longer than 120 days from referral to services, and there is a group of individuals who initially agree to participate and fail to maintain sustained engagement and/or don't make expected gains. The program may wish to consider utilizing the court petition sooner or differently as a means to encourage participation in mental health care.

Contra Costa County Assisted Outpatient Treatment (AOT) Evaluation

Fiscal Year 2016/17 Evaluation Report

Prepared by:

Resource Development Associates

September 15, 2017

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Introduction

Background Information

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

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

External Evaluation

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

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

[1] Welfare and Institutions Code, Section 5346

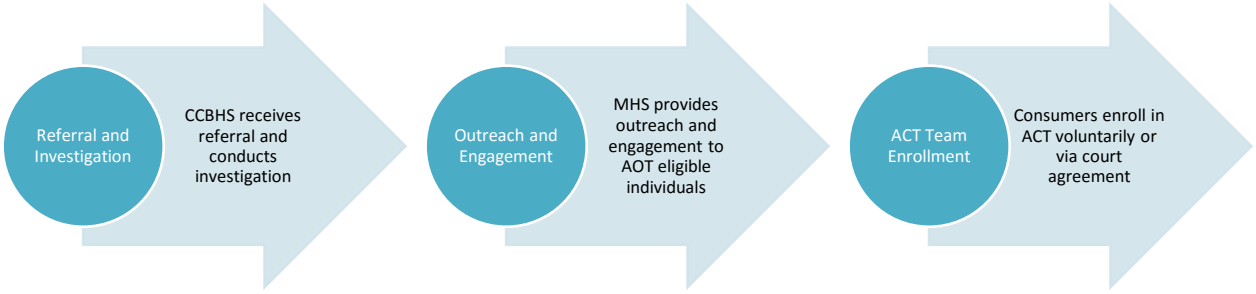
improvement. This report begins with a brief description of the AOT program's model followed by data analysis methodologies, evaluation findings, and discussion and recommendations.

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

Contra Costa County's AOT Program Model

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

Figure 1. Contra Costa County AOT Program Stages



AOT Process

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

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

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

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

AOT Process Outcomes

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

Figure 2. Process Outcomes during AOT Process

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

AOT and ACT

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

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

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

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

Methodology

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

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

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

Data Measures and Sources

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

Table 1. AOT Outcomes and Corresponding Data Measures

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

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

Table 2. Data Sources and Elements

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

Data Analysis

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

Limitations and Considerations

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

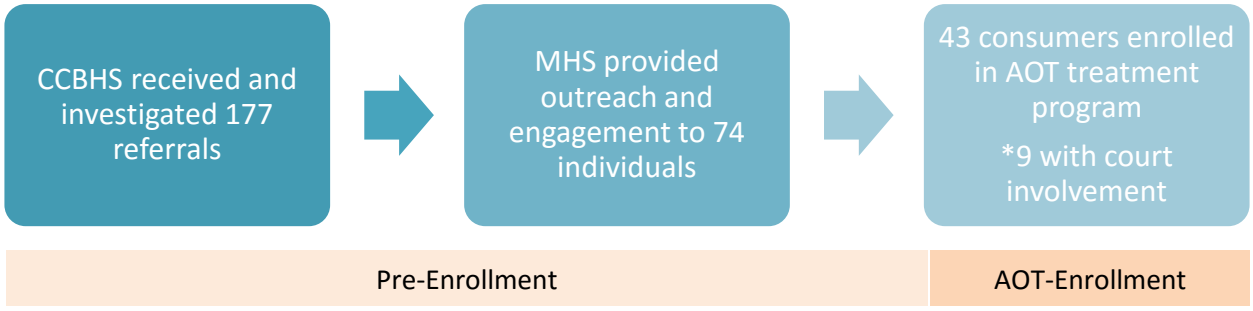
It is also important to note that there is more data available for the longer pre-enrollment time periods compared to the shorter post-enrollment time periods. Therefore, AOT consumers had greater opportunities to experience negative outcomes prior to program enrollment than after program enrollment.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

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

Findings

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

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

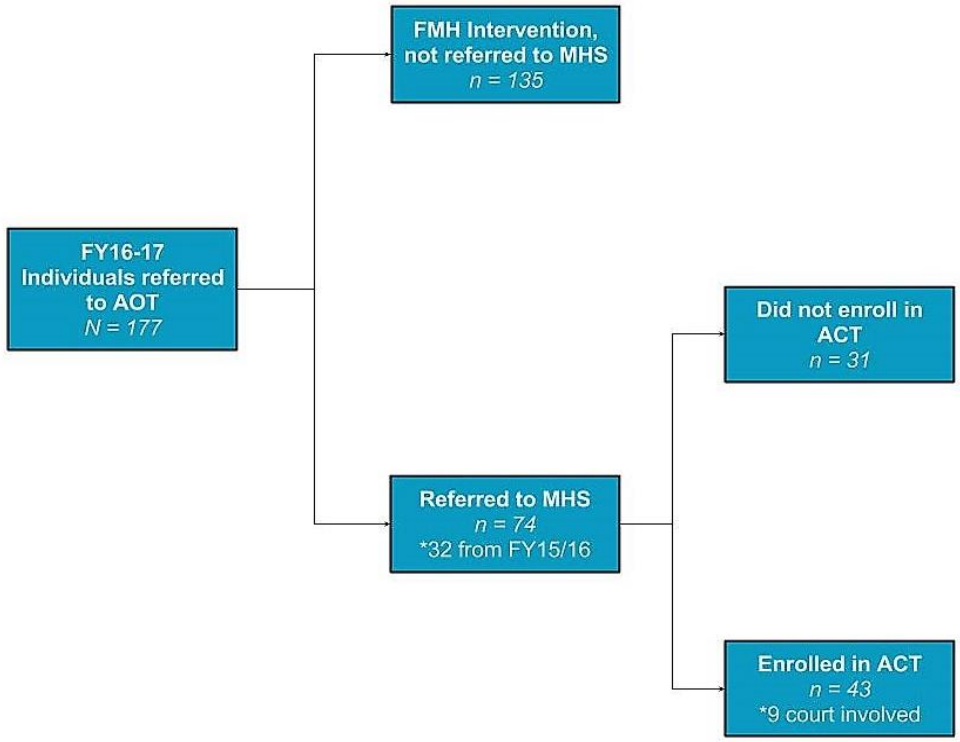


Findings are divided into two sections: "Pre-Enrollment" and "AOT Enrollment." CCBHS staff and/or MHS' ACTiOn team provide investigation, outreach, and engagement services for all individuals who are referred to AOT in order to connect them to the AOT treatment program, if eligible, or some other mental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

Pre-Enrollment

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

Figure 4. FY16/17 AOT Program



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

Referral to AOT

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

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

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

Table 3. Summary of Qualified Requestors

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

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

Care Team

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

Investigation

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

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

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

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

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

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

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

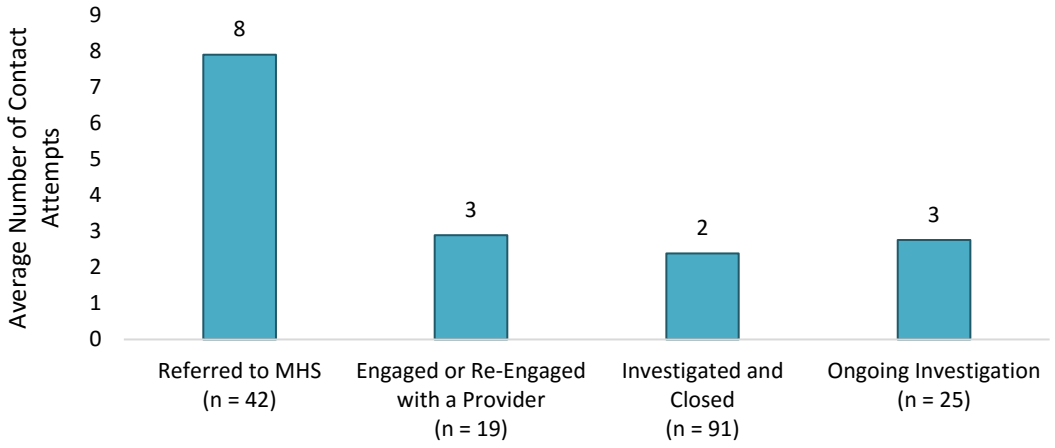
- They did not meet the AOT eligibility criteria;
- They were unable to be assessed for eligibility (i.e., unable to locate, extended incarceration, or extended hospitalization);
- The qualified requestor withdrew the referral; or
- The qualified requestor could not be reached.

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

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

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

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



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

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

Outreach and Engagement

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

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

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

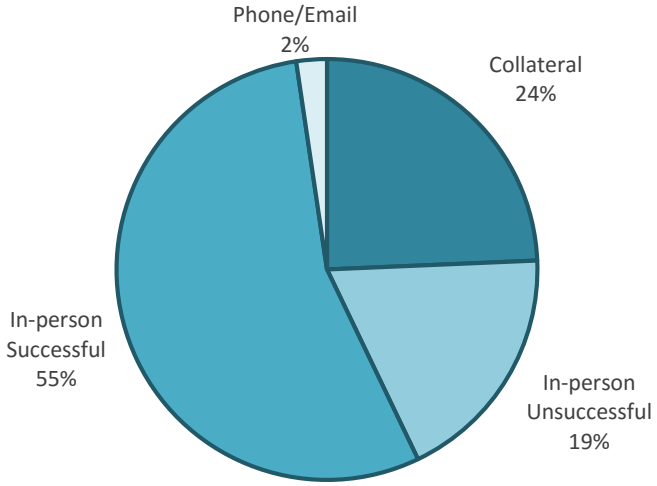
Table 5. MHS Outreach and Engagement Outcomes (N = 74)

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

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

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

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



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

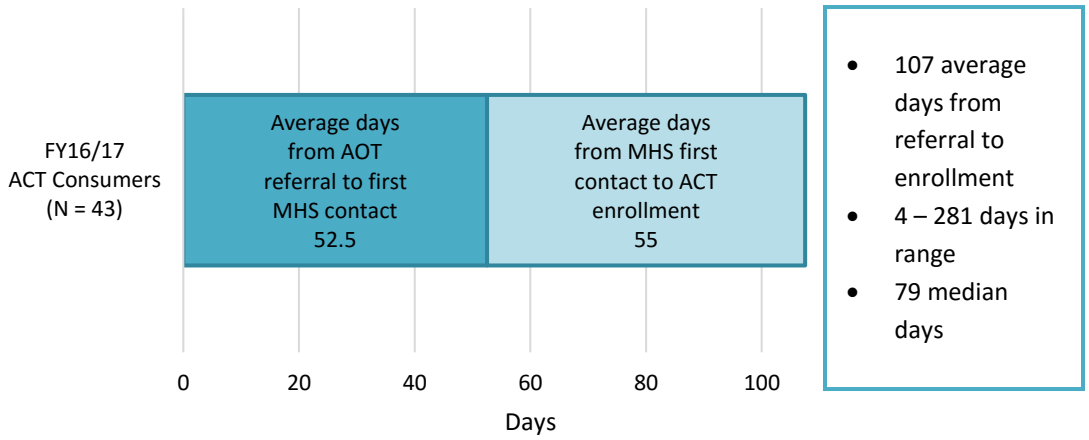
Referral to Enrollment Outcomes

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

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

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

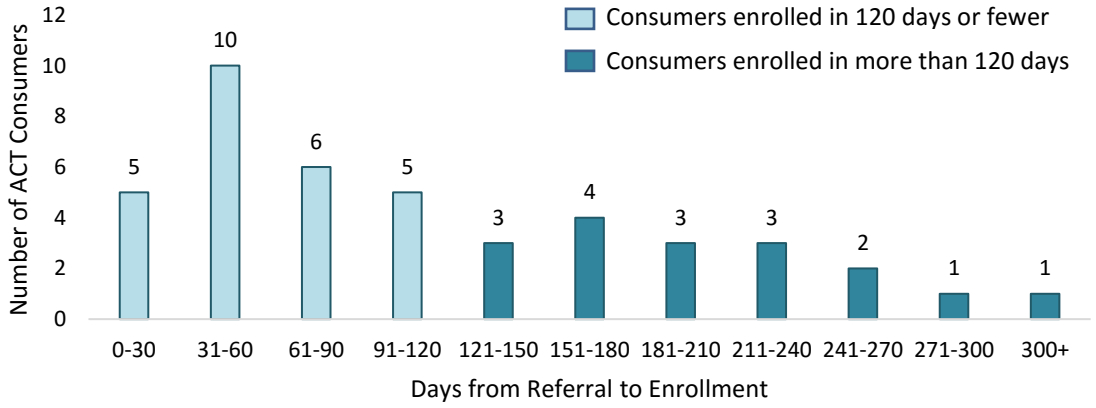
Figure 7. Average Length of Time from AOT Referral to ACT Enrollment



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

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

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

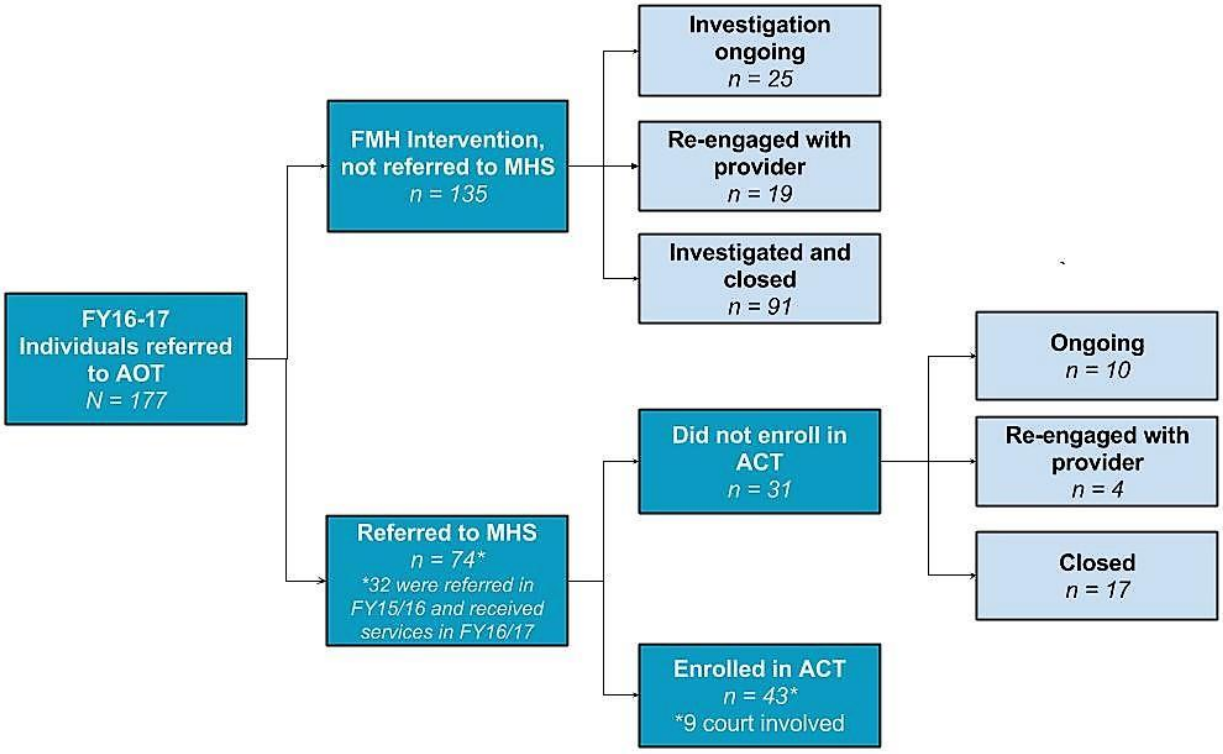


Among individuals whose pre-enrollment period lasted longer than 120 days, approximately 63% (n = 10) experienced a hospitalization and/or criminal justice involvement during this referral to enrollment period.

Summary

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

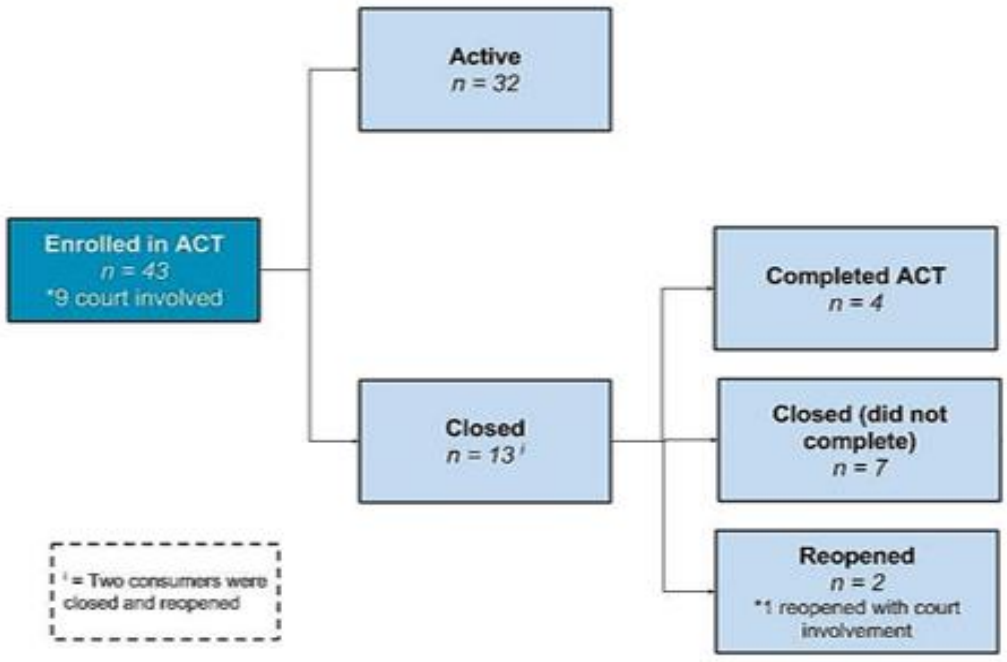
Figure 9. Referred Consumers



AOT Enrollment

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

Figure 10. FY16/17 AOT Treatment Program Participants



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

ACT Consumer Profile

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

Demographics

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

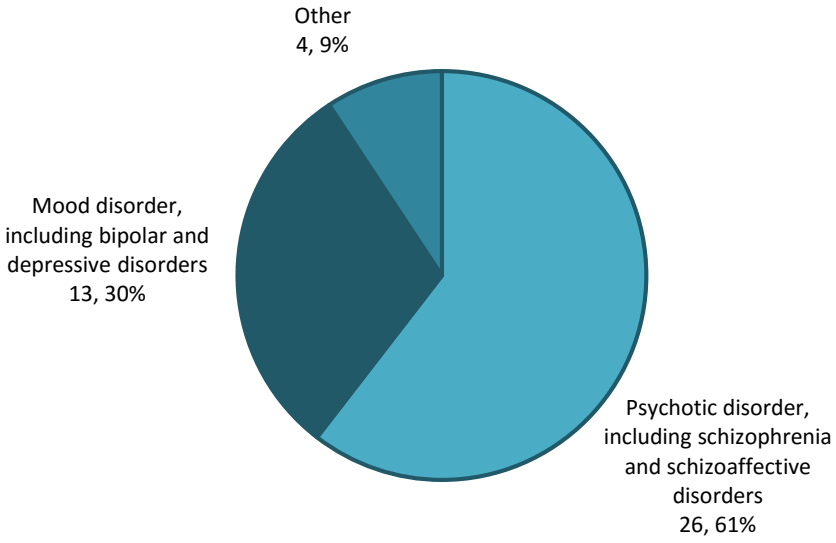
As shown in Table 6, ACT consumers were primarily male (53%, n = 23), white (56%, n = 24), and between the ages of 26 and 59 (70%, n = 30). Approximately 25% of ACT consumers are transitional age youth (TAY) between the ages of 18 and 25. While this is not completely unexpected given that the majority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

Table 6. ACT Consumer Demographics (N = 43)

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

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

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



Housing, Education, Employment, and Financial Support

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

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

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

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

Figure 12. Educational Attainment (N = 43)

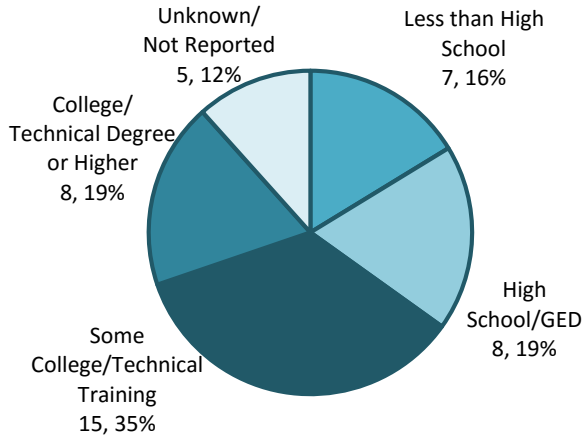
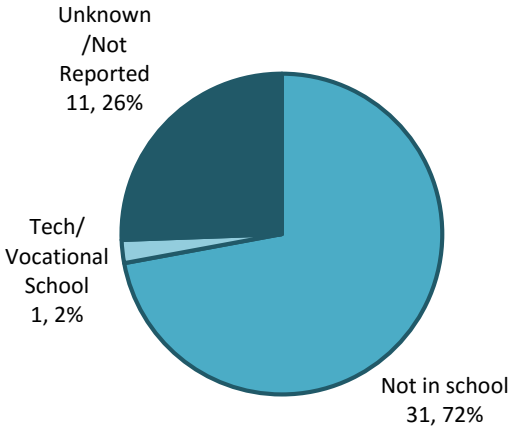


Figure 13. School Attendance at Enrollment (N = 43)



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

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

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

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

Service Participation

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

Intensity and Frequency of ACT Services

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

The ACT team continues to provide intensive services to consumers.

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

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

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

ACT Treatment Adherence and Retention

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

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

Figure 14. Intensity of ACT Contacts per Week

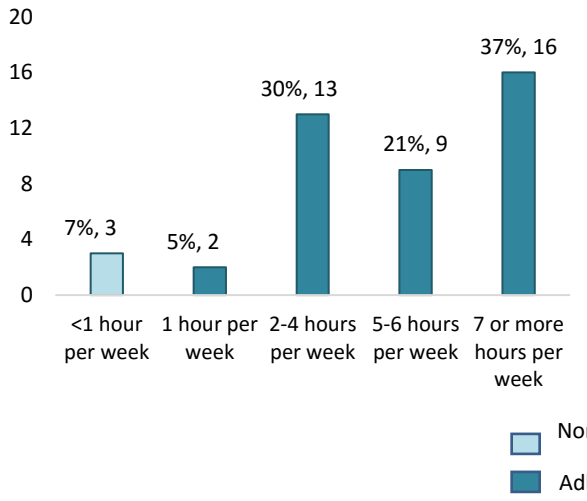
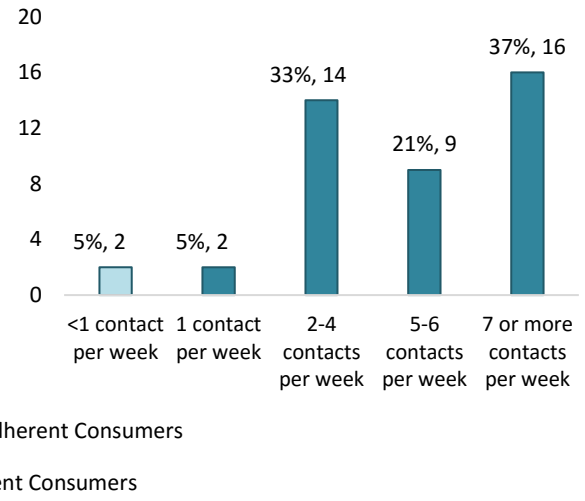


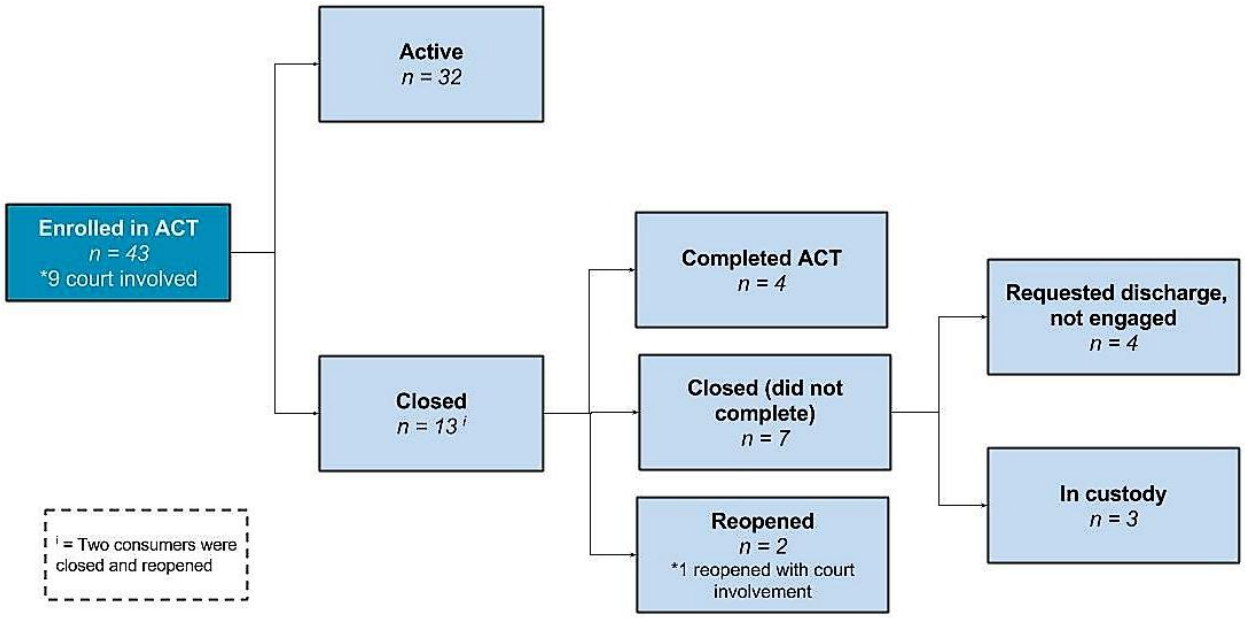
Figure 15. Frequency of ACT Contacts per Week



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

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

Figure 16. ACT Consumers



ACT Consumer Outcomes

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

Crisis and Psychiatric Hospitalization

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

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

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

Table 10. Consumers' Crisis Episodes before and during ACT

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

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

Table 11. Consumers' Psychiatric Hospitalizations before and during ACT

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

Criminal Justice Involvement

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

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

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

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

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

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

Figure 17. Criminal Justice Involvement during ACT

Figure 18. Type of Bookings during ACT

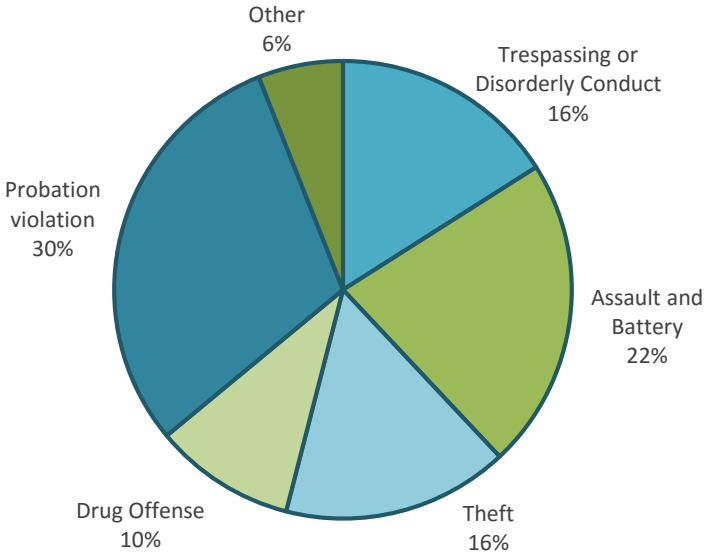


Table 12. Bookings and Incarcerations before and during ACT

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

Housing

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

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

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

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

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

A small group of consumers continues to experience difficulty.

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

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

Social Functioning and Independent Living

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

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

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

Table 13. Self Sufficiency Matrix Scores

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

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

AOT Costs and Cost Savings

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

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

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

AOT Expenses

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

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

Table 14. Contra Costa County Department Costs

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

AOT Revenue

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

Cost Savings

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

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

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

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

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

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

Discussion and Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

As such, suggested options could include:

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

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

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

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

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

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

Appendices

Appendix I. AOT Eligibility Requirements[7]

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

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

[7] Welfare and Institutions Code, Section 5346

Appendix II. Description of Evaluation Data Sources

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

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

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

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

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

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

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

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

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

Appendix III. FSP Consumer Profile

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

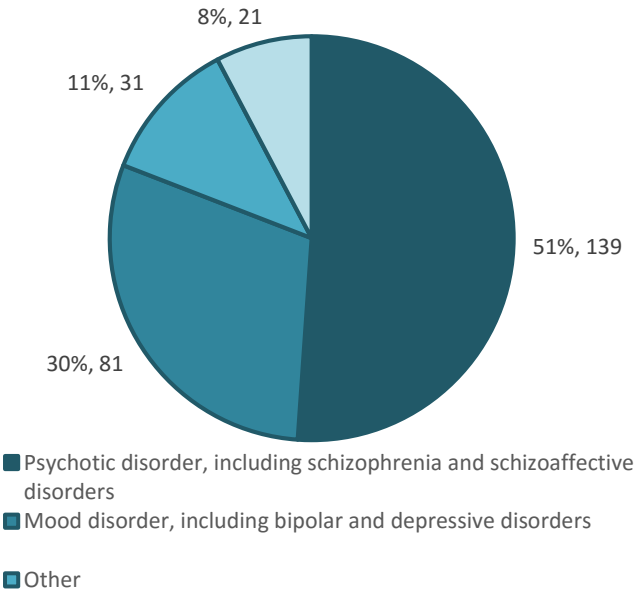
Just over half of FSP clients were male (57%, n = 156) and over half were between the ages of 26 and 59 (60%, n = 162). The majority of FSP consumers were either Black or African American (38%, n = 103) or White (33%, n = 91; see Table 16).

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

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

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

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



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

Contra Costa County Assisted Outpatient Treatment (AOT) Evaluation

MHS' ACTiOn Team 2017 Fidelity Assessment

Prepared by:

Resource Development Associates

August 21, 2017

Introduction

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

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

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

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

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

Fidelity Assessment Process

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

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

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

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

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

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

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

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

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

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

Fidelity Assessment Results

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

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

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

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

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

Human Resources: Structure and Composition

Small caseload: 5

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

Team Approach: 4

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

Program Meeting: 5

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

Practicing ACT Leader: 4

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

Continuity of Staffing: 3

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

Staff Capacity: 4

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

Psychiatrist on Team: 5

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

Nurse on Team: 5

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

Substance Abuse Specialist on Team: 5

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

Vocational Specialist on Team: 5

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

Program Size: 5

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

Organizational Boundaries

Explicit Admission Criteria: 2

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

Intake Rate: 5

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

Full Responsibility for Treatment Services: 5

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

Responsibility for Crisis Services: 5

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

Responsibility for Hospital Admissions: 5

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

Responsibility for Hospital Discharge Planning: 5

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

Time-unlimited Services: 5

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

Nature of Services

In Vivo Services: 3

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

No Drop Out Policy: 3

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

Assertive Engagement Mechanisms: 2

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

Intensity of Services: 5

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

Frequency of Contact: 4

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

Work with Informal Support Systems: 5

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

Individualized Substance Abuse Services: 5

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

Co-Occurring Treatment Groups: 5

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

Dual Disorders Model: 5

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

Role of Consumers on Team: 5

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

Other Feedback

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

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

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

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

Discussion

Strengths

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

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

Opportunities

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

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

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

Conclusion

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

CONTRA COSTA COUNTY ASSISTED OUTPATIENT TREATMENT INTERIM EVALUATION

September 25, 2017

Resource Development Associates

Agenda

2

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

3

Introduction

RDA

AOT Timeline

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

RDA

FY16/17 Interim Evaluation

5

Purpose of FY16/17 Interim Evaluation:

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

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

Data and Limitations

6

Data Provided

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

Limitations

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

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AOT Program Overview

RDA

Pre- and AOT-Enrollment

8

Referral and Investigation
CCBHS received and investigated 177 referrals

Outreach and Engagement
MHS provided outreach and engagement to 74 individuals

ACT Team Enrollment
43 consumers enrolled in AOT treatment program
*9 with court involvement

Pre-Enrollment | AOT-Enrollment

RDA

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Pre-Enrollment

RDA

Referrals and Investigations

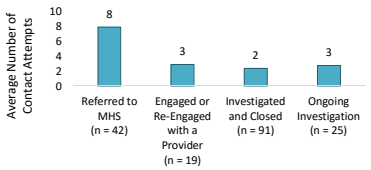
10

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

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

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

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



RDA

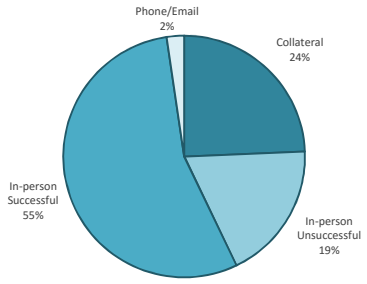
Outreach & Engagement

11

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

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

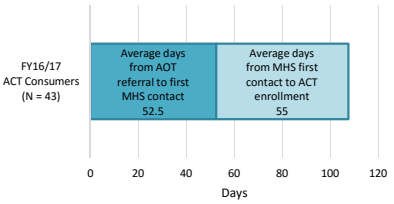
Over 80% of MHS' contacts were successful in reaching the consumer or collateral.



Referral to Enrollment Outcomes

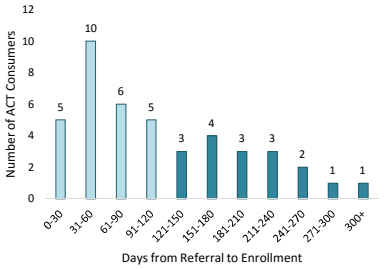
12

Average Length of Time from AOT Referral to ACT Enrollment



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

Length of Time from AOT Referral to ACT Enrollment

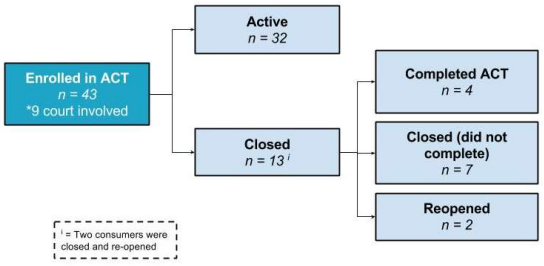


On average, for AOT treatment program consumers, it takes 107 days from the point of AOT referral to ACT enrollment.

13

AOT Enrollment

AOT Treatment Program



Consumer Profile (N = 43)

15

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

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

ACT Service Participation (N = 43)

16

ACT Services

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

ACT Treatment Adherence & Discharges

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

ACT Fidelity Assessment

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

RDA

ACT Fidelity Assessment

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Strengths

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

Opportunities

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

RDA

Psychiatric Hospitalizations and Crisis Episodes

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

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

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

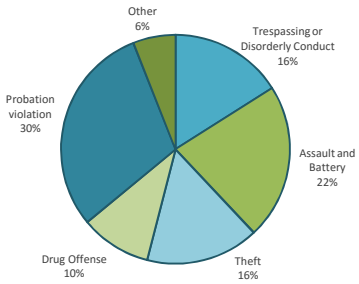
Criminal Justice Involvement

20

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

Criminal Justice Involvement during ACT

Types of Bookings during ACT



Housing Status

21

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

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

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

Social Functioning and Independent Living

22

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

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

Preliminary AOT Investments and Costs

23

AOT Investments

- Expenses

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

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

Cost Savings to Contra Costa County

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

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

RDA

24

Discussion

RDA

AOT Care Team

25

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

Consumer Outcomes

26

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

Consumers that are Challenging to Locate

27

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

Considerations for AOT Team:

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

Using the Court Petition

28

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

Considerations for AOT Team:

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

Next Steps

29

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

30

Questions and Answers

Roberta Chambers, PsyD
rchambers@resourcedevelopment.net
510.984.1478

Contra Costa County Board of Supervisors

Subcommittee Report

FAMILY AND HUMAN SERVICES COMMITTEE **5.**

Meeting Date: 09/25/2017

Subject: Annual Report on Challenges for EHSD - Continuum of Care Reform

Submitted For: FAMILY & HUMAN SERVICES COMMITTEE,

Department: County Administrator

Referral No.: 44

Referral Name: Challenges for EHSD - Continuum of Care Reform

Presenter: Kathy Gallagher, Employment and Human Services Director **Contact:** Enid Mendoza, (925) 335-1039

Referral History:

This referral to the Family and Human Services Committee (F&HS) was originally made by the Board of Supervisors on April 25, 2000. Another referral to F&HS, number 19, on Welfare Reform was referred on January 21, 1997. On January 1, 2005, the Board of Supervisors combined these two referrals so that the Department could provide updates on various aspects of their programs as the need arose. Since that time, the Family and Human Services Committee has received annual updates from the Employment and Human Services Department on a variety of issues impacting the Department.

On January 5, 2016, the Board approved the staff recommendation to carry forward this referral to the 2016 F&HS. On June 7, 2016, the Board approved the recommendation of the Employment and Human Services Director to eliminate the "Office of the Future" component of the referral and expand the referral to include a report on the Continuum of Care (Foster Care) topic.

Referral Update:

The last report on this referral came to F&HS on September 12, 2016 and was later approved by the Board of Supervisors at their November 8, 2016 meeting.

Please see the attached report from the Employment and Human Services Department, which provides an update on the Department's implementation of the Continuum of Care Reform (AB 403) and their efforts to improve services to dependent children and youth.

Recommendation(s)/Next Step(s):

CONSIDER accepting the report from the Employment and Human Services Department on the foster care Continuum of Care Reform implementation efforts and forwarding it to the Board of Supervisors for their information.

Fiscal Impact (if any):

There is no fiscal impact, the report is informational.

Attachments

Report on Continuum of Care Reform Implementation

Continuum of Care Reform Implementation Presentation Slides

EMPLOYMENT AND HUMAN SERVICES
CONTRA COSTA COUNTY

TO: Family Human Services Committee **DATE**: September 25, 2017
David Twa

FROM: Kathy Gallagher, Director, Employment and Human Services Department
Kathy Marsh, Director, Children and Family Services Bureau

SUBJECT: Continuum of Care Reform (CCR)

RECOMMENDATION

Accept this report from the Employment and Human Services Department; and continue to support the Children and Family Services (CFS) Bureau and its efforts to improve services to dependent children and youth.

BACKGROUND

The Continuum of Care Reform, AB 403, is a comprehensive reform effort built on many years of policy changes designed to improve outcomes for youth in foster care. The goal is to ensure that youth in foster care have their day-to-day physical, mental, and emotional needs met; that they have the greatest chance to grow up in permanent and supportive homes; and that they have the opportunity to grow into self-sufficient, successful adults.

FUNDAMENTAL PRINCIPLES OF CCR:

All children deserve to live with a committed, nurturing, and permanent family that prepares the youth for a successful transition into adulthood.

The goal for all children in foster care is safety, permanency and well being while establishing permanent life-long relationships. CCR guides the transition away from the traditional use of long-term group home care by transforming existing group home care into short term, residential treatment programs for youth who are not ready to live with families in home-based care.

All placement types should be able to provide access to the services and supports, including behavioral and mental health services that the child in placement needs.

Agencies serving children and youth including; child welfare, probation, mental health, education, and other community service providers, need to collaborate effectively to

surround the child and family with needed services, resources and supports rather than requiring the child and caregivers to navigate multiple service providers.

Both the child and family's experience and voice are important in assessment, placement and service planning. Child and Family Team meetings, which include the child, family, and members of their formal and informal support network, will meet as a foundation for ensuring all perspectives are considered throughout the life of the case.

PROGRESS TO DATE:

Contra Costa County implemented Resource Family Approval (RFA) January 1, 2017. RFA is an important shift in the way that Children and Family Services approves caregivers as it supports placement with families that can provide a lifelong connection by determining permanency approval upfront.

EHSD has a collaborative CCR Executive Team and a Steering Committee with management representatives from Children and Family Services, the CAO's office, Behavioral Health Department, and Probation Department to guide workgroups tasked with different components of CCR, such as Child and Family Team Meetings, Group Homes and Foster Family Agencies, Training, and Data.

Children and Family Services is regularly collecting data on the (approximately) one hundred dependent children who are currently in group home placements to assess their potential for stepping down to home-based care and to determine their specific services and treatment needs.

Children and Family Services has also been meeting with providers, including Group Homes and Foster Family Agencies (FFAs) in order to communicate the needs of Contra Costa County dependents and assist them with their transition to CCR.

Over the past year and a half, Children and Family Services has also developed new strategies and a renewed focus on recruiting and retaining quality non-relative and relative resource families.

SUMMARY/CONCLUSION

The Continuum of Care Reform draws together a series of existing and new reforms to our child welfare services program designed out of an understanding that children who must live apart from their biological parents do best when they are cared for in committed, nurturing family homes. AB 403 provides the statutory and policy framework to ensure services and supports provided to the child and his or her family are tailored toward the ultimate goal of maintaining a stable, permanent family.

With the Board's support and commitment to the Continuum of Care Reform, EHSD will utilize CCR to better meet the needs of our dependent children and to promote positive outcomes for youth as they transition out of foster care.

California's Child Welfare

Continuum of Care Reform (CCR)

Overview For Contra Costa County

THE CONTINUUM OF CARE REFORM

CCR is mandated by AB 403 and is a comprehensive framework that supports children, youth and families across placement settings in achieving permanency.

CCR includes:

- Increased engagement with children, youth and families
- Increased capacity for home-based family care
- Limited use of group home care
- Changes in rates, training, accreditation, mental health services and accountability & performance

VISION OF CCR

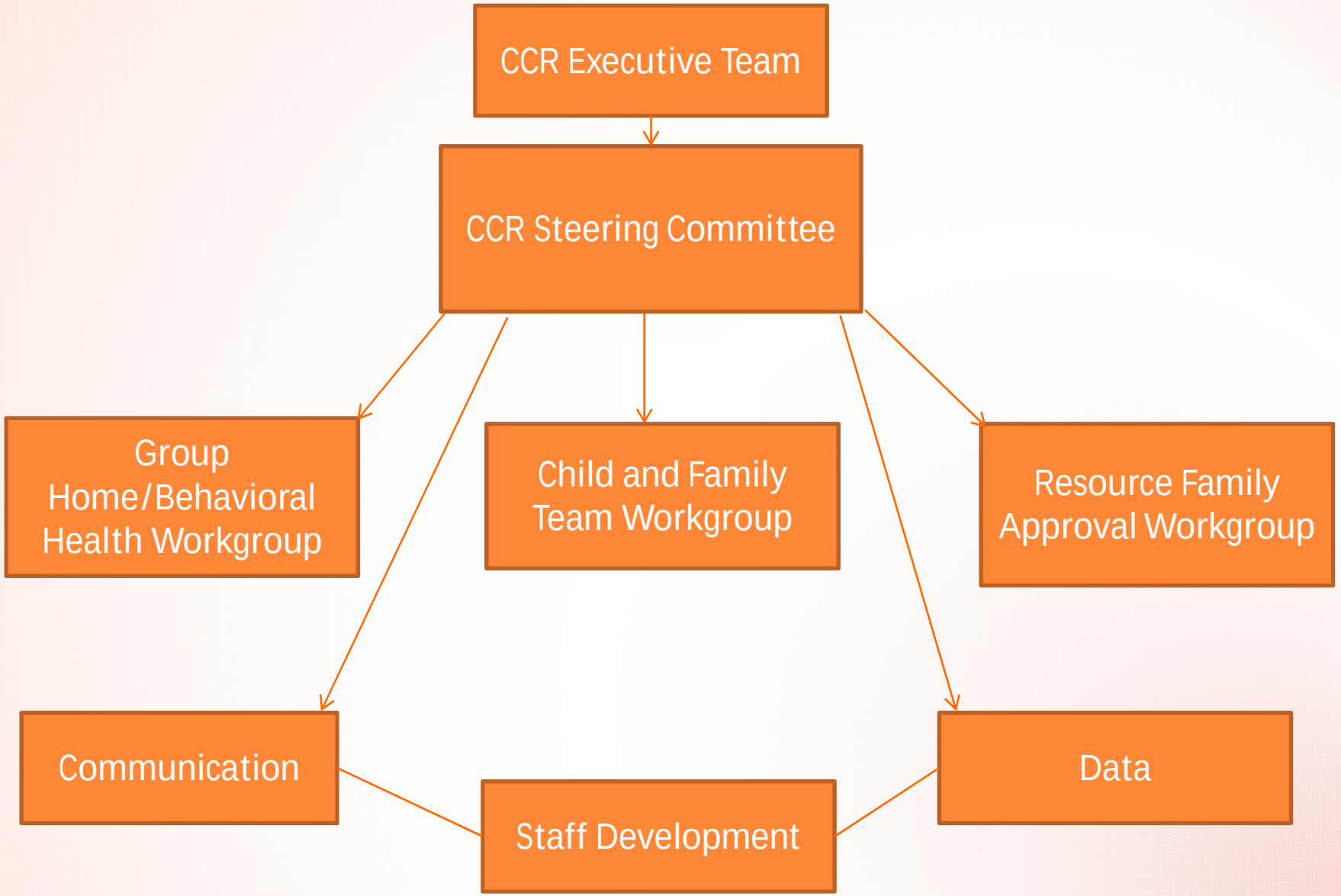
All children live with a committed, permanent and nurturing family

Individualized and coordinated services and supports

Focus on permanent family and preparation for successful adulthood

Group Home care, when needed, is a short-term, high quality, intensive intervention that is just one part of a continuum of care available for children, youth and young adults

CCR Implementation Structure



THE PARADIGM SHIFT

Group Home → *Short Term Residential Treatment Program (STRTP)*

Children who cannot be safely placed in a family setting, and who meet the specific criteria can receive short-term, residential care with intensive therapeutic interventions and services to support their transition to home based family care.

GROUP HOME/BEHAVIORAL HEALTH WORKGROUP

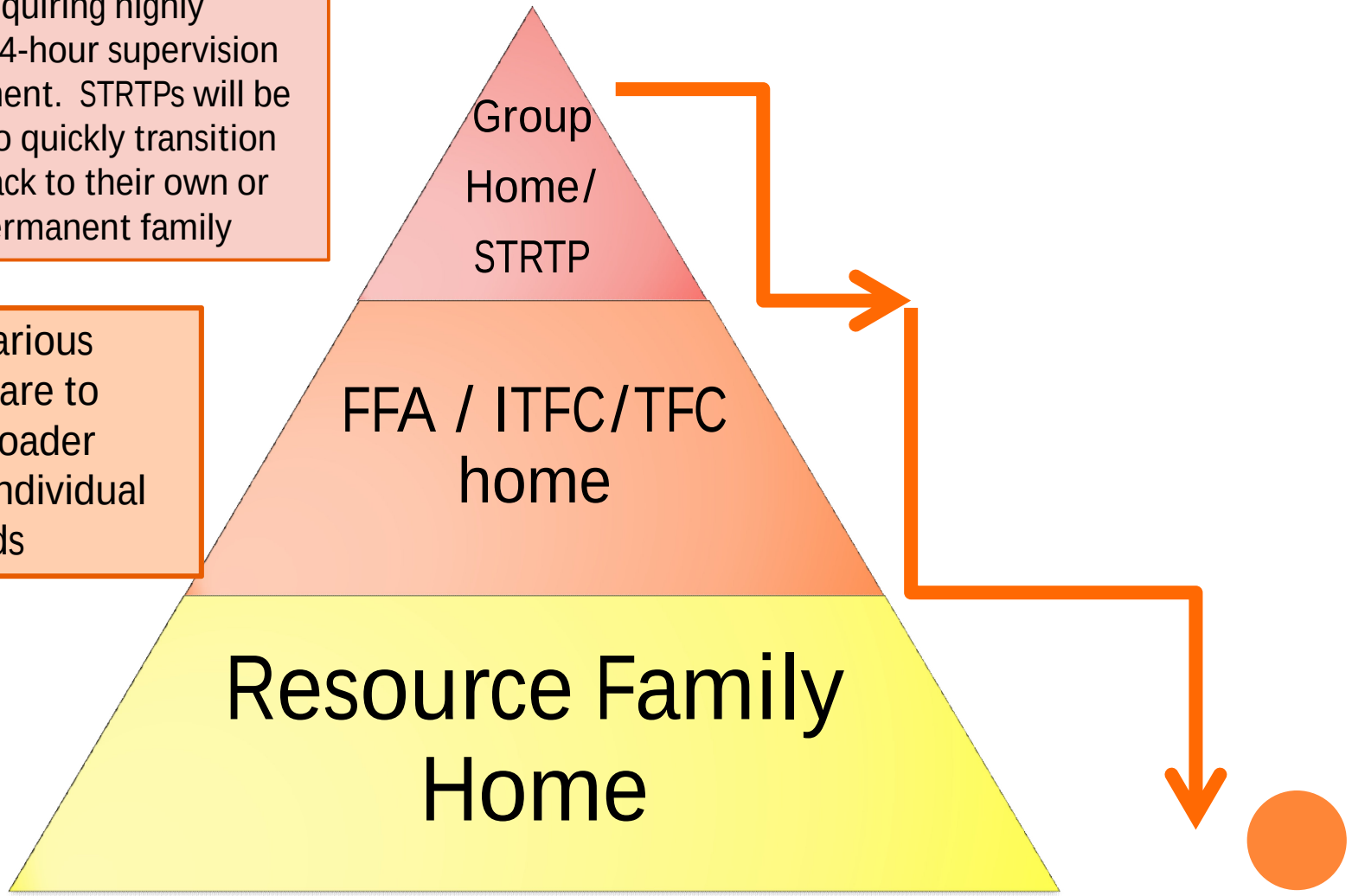
Meeting regularly since early 2016 to plan for transition of youth from congregate care to Home Based Family Care

- Workgroup Highlights:
  - *Support Group Homes in their transition to STRTPs*
  - *Identify youth who will require STRTP level placement*
  - *Support Foster Family Agencies (FFAs) in expanding their capacity to accommodate High Needs Youth*
  - *Work with Mental Health to identify and arrange necessary supports in place for those placements accepting High Needs Youth*
  - *Preparation for Step Downs…*

STEPPING DOWN TO HOME BASED CARE

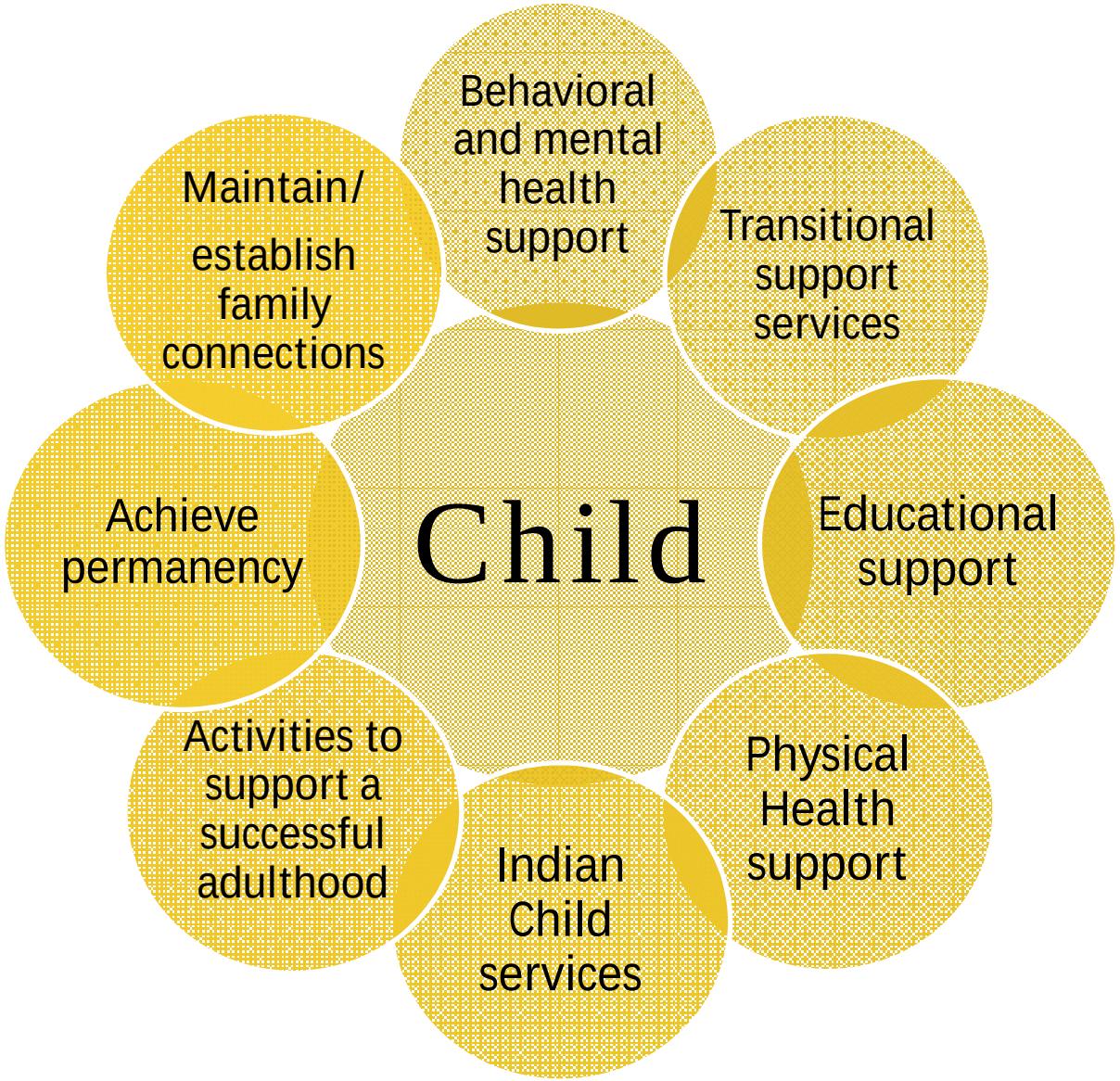
Children requiring highly intensive 24-hour supervision and treatment. STRTPs will be designed to quickly transition children back to their own or another permanent family

Provide various levels of care to meet a broader range of individual child needs



CORE SERVICES:

All placement types will be held to higher standards and be accountable to coordinated care among all service providers.



Increased Behavioral Health Services

Intensive Care Coordinators (ICC): assigned to children who meet medical neccesity criteria to facilitate teaming and coordinate mental health care

From 01/2017 – 07/2017

216 ICC eligibility screenings complete	62 clients closed out of ICC services	389 referrals
71 were eligible and referred to ICC services	Based on meeting goals and no longer needing additional services	made to Care Managed Unit for outpatient therapy referrals for children with mild to moderate symptoms

Total open ICC cases as of 07/2017: 326

CCR Core Element:
Increased Engagement

- Child & Family Team(CFT)
  - Up-front and continuing assessment that includes youth, family members, and their formal and informal support network collaborating in regards to support, services, and placement needs of the youth and family

CFT WORKGROUP

A Child and Family Team workgroup meets regularly to work towards:

- *Holding CFT meetings for all open cases within 60 days*
- *Holding a CFT meeting not less than once every 6 months for all open cases*
- *Holding a CFT meeting once every 90 days for youth who are placed in an STRTP (and/or meet special mental health criteria)*
- *Inviting appropriate resources, i.e., Domestic Violence Liaisons, Public Health Nurses, etc.*
- *Ensuring a voice for families and the child*

CHILD AND FAMILY TEAM (CFT)

- CCC has hired 4 Full Time CFT Facilitators and contracted out assistance from another agency for the 6 month review CFTs and Youth Transition Meetings (YTM).

When and how do the members of the CFT communicate?

- The CFT members can communicate in many ways: phone calls, conference calls, emails, and in-person meetings
- The CFT meets at key times during an open case to get feed-back on child/youth/family progress and update the action steps to well-being
- The length of meetings will be based on need but typically will not last more than 1.5 hours
- CFT communication may include certain CFT members at some times and all members at other times.
- The children/youth and/or parent may call a CFT meeting by calling their Children and Family Services worker

Our CFT Members

NAME	PHONE NUMBER

Your next CFT meeting is:

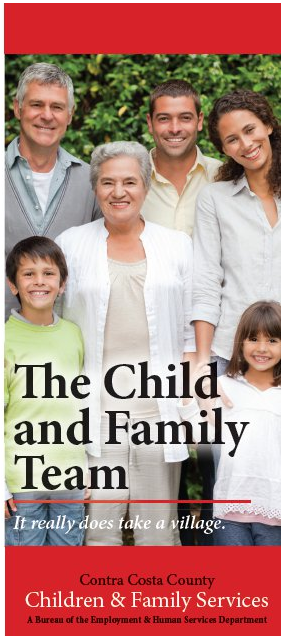
Date: _____

Time: _____

Location: _____

Contra Costa County
Children & Family Services
A Bureau of the Employment & Human Services Department
www.ehsd.org

CONTRA COSTA COUNTY
EMPLOYMENT & HUMAN SERVICES



What is a Child and Family Team?

A child and family team (CFT) is comprised of the family, their natural supports, and all of the individuals who are working with them towards successful transition out of the child welfare system.

What is the role of CFT members?

- Support hope, healing, and resilience
- Share strengths, concerns, and ideas to support the family
- Develop and implement steps to support the family's well-being
- Communicate regularly with the CFT

Who participates in a CFT?

Together, the children/youth and family and Children and Family Services worker will identify CFT members. Typically, the core CFT members are:

- The child/youth
- Family (parents, legal guardians, etc)
- Social worker/any CFS support involved
- Extended family
- Caregivers
- Service providers
- Youth/Parent Partners
- Mental Health Partners
- Coaches/teachers
- Neighbors
- Others who support the family

Guidelines for effective communication

- All participants must actively contribute by being direct, honest, and respectful
- Everyone's voice is important and each participant will have the opportunity to be heard.
- All action steps will be mutually agreed upon and assigned based on strengths of each CFT member
- Participants ability to commit to support decisions made and assist one another in completing actions steps

CFT principles

- Teaming promotes decisions that rely on the voice of the children/youth and family
- It embraces and requires family participation in creation action steps
- It values children/youth and families as equal partners
- It recognizes and appreciates the family's culture and devises action steps that draw on it

How is a CFT meeting structured?

- Clearly defined purpose, goal, and agenda
- Focused meetings
- Agreed-upon decision-making process
- Identification of family strengths and needs
- Brainstorming all options available to support the family
- Specific action steps and timelines developed for the team members
- Focus on times of transition

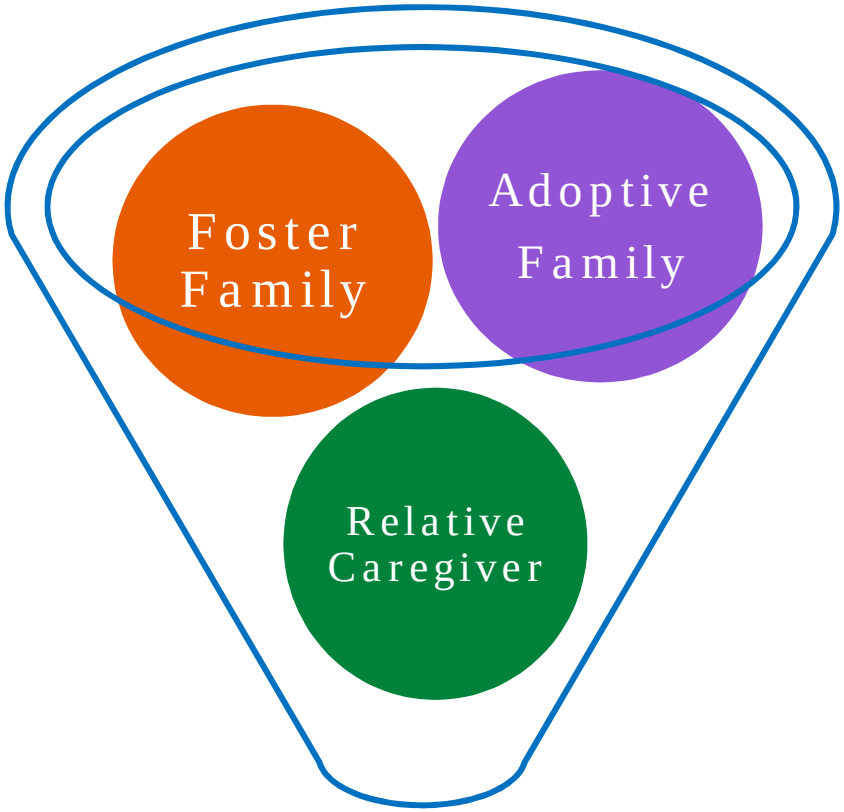
SINCE JANUARY 1…

CCC CFS has completed 302 CFT meetings between 01/2017 and 07/2017

- 164 Team Decision Making/CFT meetings (referral)
- 21 Court CFTs
- 35 Continuing/Intensive Family Services meetings
- 20 placement disruption
- 62 Youth Transition Meetings

CCR also includes another big shift from:

Foster Families/Relatives → Resource Families



Resource Family

Resource Family Approval:

- A new single, unified process for approving all caregivers, including: Kin, Non Related Extended Family Members (NREFM), licensed foster families, and FFA foster families

Resource Family Approval Workgroup

Meeting monthly since late 2015 to:

- *Plan and implement Resource Family Approval effective 01/01/2017*
  - *Train staff and caregivers to meet new RFA standards*
- *Improve emergency relative placement and overall relative placements*
- *Plan for conversion of existing licensed foster homes and approved relative homes*
- *Develop recruitment, training and support of current and prospective caregivers*

RFA Application Data

Consistently 40-45 Resource Family applications per month since 04/2017

On average, from 4/2017 – 06/2017, 2/3 of the applications are relatives/NREFMs

RESOURCE FAMILY APPROVAL

Challenges

- Length of application/approval process
- Pre-Approval training requirement for all potential caregivers
- Short timelines
- Staffing
- Conversion of existing Approved Relative /Licensed Fother Homes

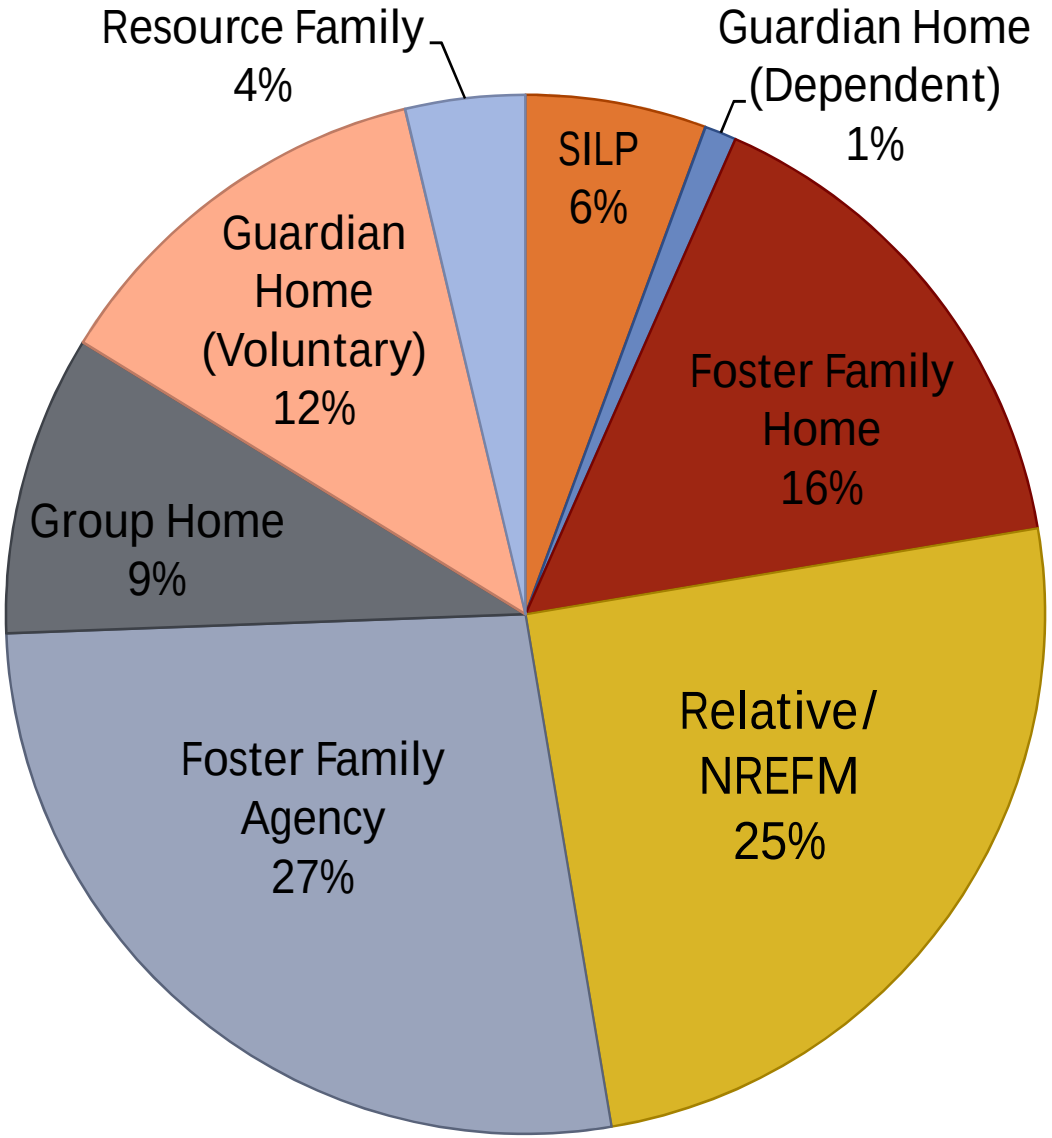
Successes

- Increased Emergency Placements
- New Resource Family Approval database
- Reorganization and restructuring of existing staff
- Increased applications
- Regional collaboration

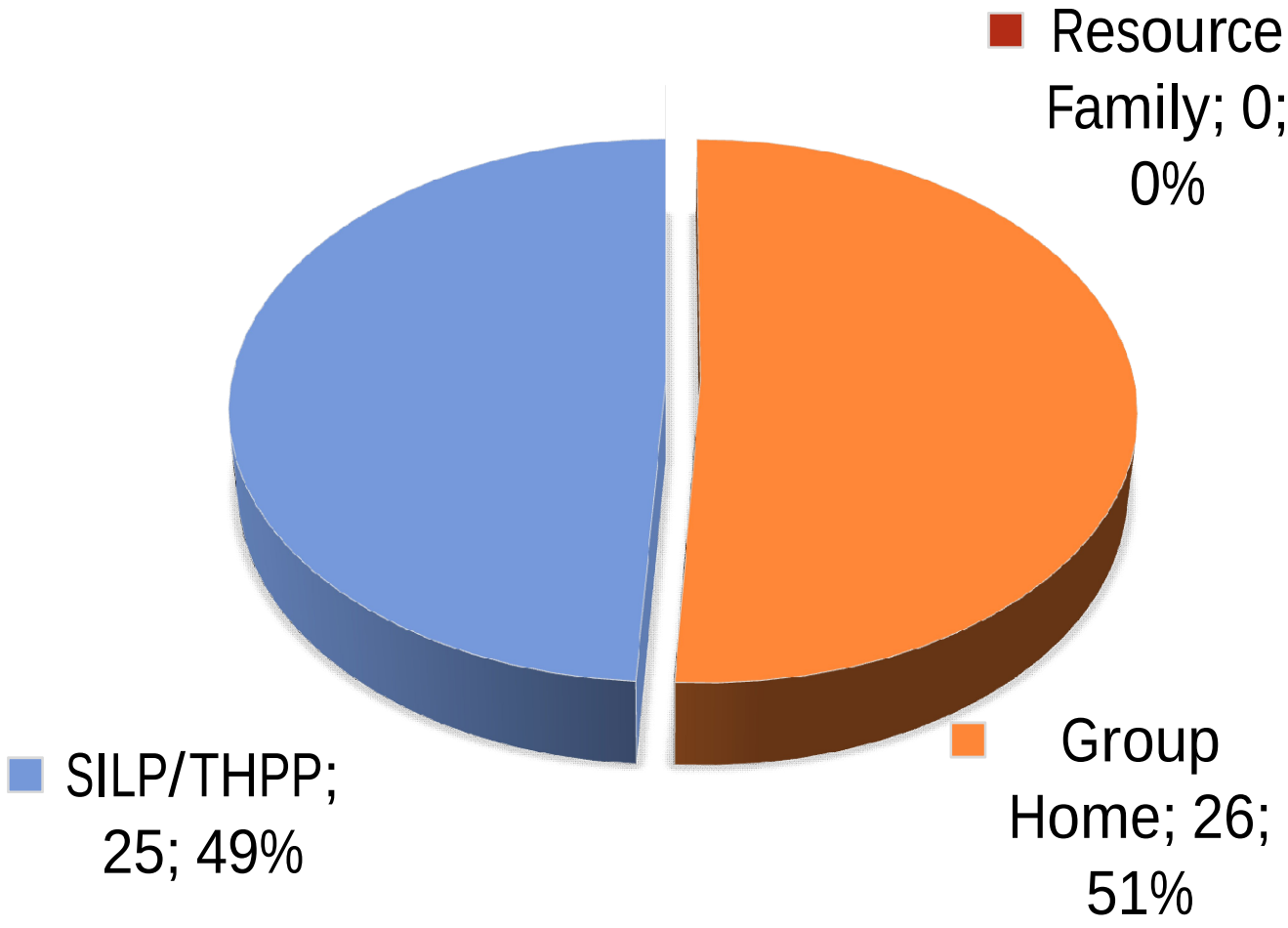
CONTRA COSTA COUNTY PLACEMENT RESOURCE DATA

- 80% of dependent children's placements will be affected by CCR
  - 328 total approved relative homes and Licensed Foster Homes will need to be converted to RFA homes

CHILDREN & FAMILY SERVICES PLACEMENTS



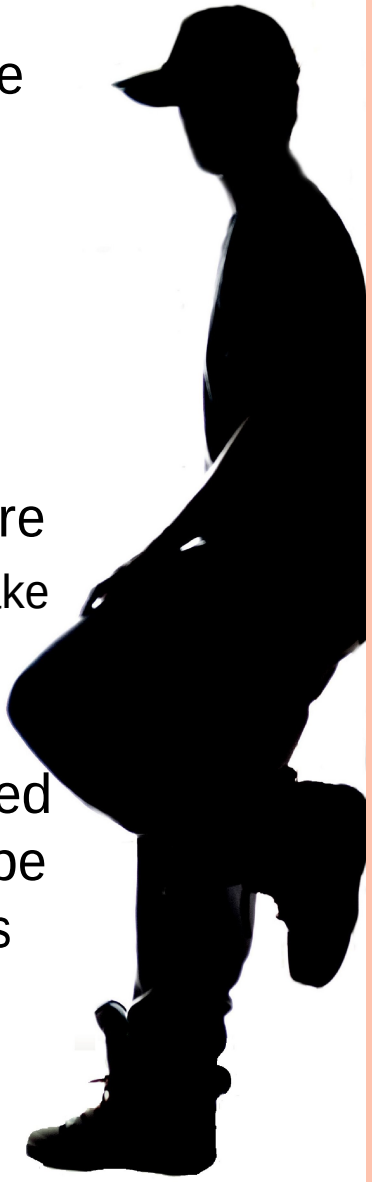
CONTRA COSTA PROBATION PLACEMENTS



SILP: Supervised Independent Living Placement
THPP: Transitional Housing Placement Program

PLACEMENT IMPACT – CFS CHILDREN

- 42 children will need to transition from Group Home placements to STRTPs
  - Very few group homes have successfully made this transition successfully yet
- 55 children will need to transition from a Group Home placement to a lower level of Home Based Care
  - CCC will need home based caregivers that are willing to take dependents with higher needs levels
- The most difficult 1% of dependent youth will still need specialized placement and their needs still may not be met by STRTPs. Counties are presenting these cases to the state for review.



Implications for Contra Costa County

CCC needs to actively recruit and approve more Resource Family Homes

Response:

- Increased recruitment: buses, movie theater ads
- Targeted recruitment for older youth and high needs youth

CCC needs to develop additional services to support youth formerly in Group Homes now in home based settings

Response:

- CFS has entered into a Mental Health interagency agreement to provide additional mental mealth services to support youth in home based family care
- Mental Health has begun expansion of specialty services such as Parent Partners, Emergency Foster Care Unit, ICCs

Additional Implication:

Updated Provider Rate Structure

- Phase 1 implemented 01/01/2017 and established one rate for Resource Family Homes, Licensed Foster Homes, Relatives, NREFMs, and NMDs in Supervised Independent Living Placements
  - Rate structure for FFAs includes a detailed breakdown of rate for Admin, Social Worker, the Certified Family, etc.
  - One STRTP rate for all STRTP facilities

- Phase 2 goes into effect 12/01/2017 and includes a new Home Based Foster Care LOC Protocol and Intensive Services Foster Care rates to support children in placement with more specific and/or specialized needs

CHALLENGES AHEAD

- Some Group Homes will not be able to make the conversion to STRTP resulting in few placement options for high needs youth

- Recruiting Foster Families
  - Increase Family Finding
  - Increase community awareness of need for caregivers and the specific needs of our youth

- In Home supports needed for caregivers and for children entering home based family care
  - In order for step downs to be successful, appropriate supportive services will need to be in place
  - Lack of interest in becoming TFC

Mental Health Services Challenges

Increased need of Outpatient and Crisis services that will require greater resources and Staffing

Increased need for Utilization Review, authorization, and monitoring of Service delivery and documentation

Additional resources needed to monitor and facilitate the implementation of EPSDT Specialty Mental Health Services by FFA's and Foster homes, as well as provide Mental Health Consultation and Training.

LOOKING AHEAD

and Probation will continue to collaborate as we address the challenges and implications of CCR to effectively meet the needs of the children and families we serve.