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Board Laura's Law Initial Evaluation Remarks—12/20/2016—Douglas Dunn

I'm Douglas Dunn and referred our gravely mentally ill loved one into this most vitally needed program for which families are extremely grateful. I have recommendations to make it the best in the state; but, first 2 important points about this population.

- Above and beyond stigma, they, like our loved one, have severe anosognosia which medically means they have no awareness they live with a severe mental illness. As a result, they do not see any need for treatment.
- Each psychotic break tends to further damage their brain and makes meaningful recovery much harder if not impossible to attain. With at least 17 psychotic breaks, 8 in the past 18 months alone, our loved one is a tragic example.

As a recognized citizen expert on Laura's Law, I receive 10-15 phone calls/week from frantic family members who have referred their loved to this program without timely county response. Despite frantic repeated calls, no response for up to a month at a time. In the meantime their loved ones totally decompensate to the point of being homeless where the county cannot effectively outreach, engage, or investigate the referral. After my remarks at the Family & Human Services meeting Mon., Dec. 12, the county leader of this program contacted behavioral health system family advocates who independently confirmed that they too, get very similar weekly calls. FYI, per the evaluation report (pp. 12, 13, and 54) county behavioral health cannot electronically track these calls and any call backs.

In addition, my own "due diligence" shows that increasing numbers of post-July 31 referrals come from law enforcement and Mental Health Evaluation Team (MHET) referrals. Because of the increasing workload, county behavioral health apparently cannot handle the "front end" outreach, engagement, and referral investigation process in a time-critical manner. Personally, I believe the new Laura's Law (AOT) court is being used to "fill in the gaps" due to Contra Costa's lack of range of mental health courts that exist in other urban California counties.

Our loved one voluntarily enrolled in this program in mid-June, 2016. This, after 5 hospitalizations in a Full Service Partnership costing nearly $40,000 in 11 months. Since his voluntary acceptance in June, there has been 3 additional hospitalizations cost nearly $25,000 so far. Despite disengagement, there is extreme reluctance to use the court order process. This shows throughout the 61 page report, esp. on page 44.

Recommendations:

- Direct Behavioral Health to greatly streamline the referral investigation process (5 days max.) and delegate to the Mental Health Systems Contra Costa ACTiOn Team all other outreach and engagement activities. Increasing to 75 clients within the next 6 months will require this change.
- Mandate an all-inclusive program electronic records process as soon as possible.
- Require that county departments actively pursue additional mental health courts grant funding opportunities as provided for in the new 21st Century CURES Act President Obama signed into law December 13.
- Direct and strongly encourage use of the court order process whenever a client either will not engage, or markedly disengages after voluntary agreement. Studies show this is the most cost and treatment effective Assisted Outpatient Treatment approach. Our loved one's life may depend on it!
- Require quarterly Oversight meetings like LA & San Francisco counties have done.

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Date: 12/20/16

Comments and Questions: Research Development Associates (RDA) 2016 Assisted Outpatient Treatment Evaluation Report presentation to the Mental Health Commission on 12/14/16

Submitted by: Barbara Serwin, Vice-Chair, Mental Health Commission

My major concerns with respect to the RDA report and initial six month implementation phase of the new County AOT program are 1) costs; 2) projections for the number of patients; and 3) the business case for projected lower costs of the new AOT services versus the costs of services pre-Laura's Law.

COSTS: The $905k paid to Mental Health Services, the service provider for AOT services, for the startup phase plus the first six months of operation, was spent on 17 clients rather than the 75 that were projected. If county costs were added in (e.g. CCBHS, Superior Court), which total another $416k, the total spent would be $1.3M.

I ask the question of how the program could have spent $1.3M or even just the $905 billed by Mental Health Services during the start-up and first six months of the program on just 17 clients. During the presentation* I was told that because the team is multi-disciplinary, multiple staff had to be hired at once. This makes sense to have full representation of each type of staff required, but the number of psychiatrists hired on at the beginning of the program did not have to be the full five that were actually hired; it could have ramped up the number of psychiatrists. This goes the same for nurses, substance abuse specialists and vocational specialists on the team. The apparent lack of a ramp up plan for the case of a low number of clients resulted in a lot of wasted money.

During the RDA presentation I didn't have the chance to ask how this fully built-out team spent the ~~year~~ first six months when they were NOT working with

* made to the Mental Health Commission on 12-14-16

the 17 patients.

One other point that was raised in this area -- RDA acknowledged that they are concerned about how to scale the team up to cope with the projected 75 clients. Why would that be a concern when the team is ~~supposed~~ already staffed to serve 75? I didn't have the opportunity to ask why during the presentation.

PROJECTED NUMBER OF CLIENTS: My second concern is the question of how the number of patients was projected for their second ~~year,~~ 6 months which is 75. I learned from Jill Ray that there had been a workgroup that did the first year projections and from Lauren Retaggliata that the hospital had analyzed its client and PES databases for relevant numbers. I asked RDA how the projections for the second six months of the program were made. The staff in charge appeared uncertain about what I meant by this question. It seems as though the team simply adopted 75 patients again. They didn't say there was any explicit thinking about this point. They answered the question from the position of "well, we have 37 patients now and we are investigating 37 more". The first six months projections were WAY off and with these kind of dollars on the line, rethinking second six month projections is critical. Hopefully there are identifiable reasons for the gross inaccuracy that are specific to the first year learning curve and having to prime the pump with qualified clients.

SAVINGS PROJECTIONS: My last concern is regarding the relative costs of pre-Laura's Law versus the current Laura's Law implementation model. RDA does not have enough data to determine whether costs for the implemented solution will be less than prior costs. However, there was no mention of a business model for evaluating different scenarios. Right now it is all a hypothetical. I

understand not having the data yet but it's concerning if there is no model in place to answer the question of whether the model is a cost effective approach and whether the cost can be reigned in to some more sustainable level. I don't know if there even is a targeted cost amount.

Submitted respectfully,

Barbara Serwin
Vice-Chair, Mental Health Commission

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I am Teresa Pasquini, a local, state and national advocate for reforming our mental illness systems. I respectfully urge that there must be action taken today to form an AOT Oversight work group that is focused on creating a continuous improvement process for the Contra Costa County Laura's Law program. The original AOT Workgroup has not met since last April. It must be reconvened and new members added based on the issues that have been highlighted in this RDA report.

I have reviewed this report, listened to the tape of the MHC's discussion of the report and submitted comments to the FHS Committee. My comments were centered around the obvious reluctance to use the court petitions for those difficult to engage patients. If we are only using the ACT model and not the court ordered judicial piece of AOT, then how are we to know whether the "black robe effect" and court supervision truly does lead to improved outcomes? Without this piece, this is not AOT. That was not this Board's direction or the community's intention.

This evaluation is a great start at honing in on some of the issues faced in the program's implementation. Now we need a process implemented to immediately fix the program gaps. I fear that the program is currently being used to fix system gaps that it was not designed to accommodate. For example, a FACT team was not part of the original program design even though this may be a great and needed addition.

I am mostly concerned with communication issues and lack of clarity on who can and cannot make a referral along with the confusing and elongated investigation and engagement and outreach process. This is causing harm by preventing safe, effective, timely, efficient, equitable and patient and family centered care to those who have suffered too much for too long. We are making it harder then it has to be. We can and must do better for the patients, the families and the staff who serve both.

To support my concerns, I am providing a Timeline of communications that began in February 2016 when I originally requested that the system consider an AOT referral for a young homeless woman who we

once took into our home. After months of outreach and engagement attempts, several forced hospital stays, crisis residential stays, AWOLs and police interactions, I finally received confirmation, last Thursday, that there is now an open AOT investigation.

It should not take 10 months to get someone into the AOT engagement process who qualified back in Feb 2016. And, it should not have to be so hard to help someone who is hiding in plane sight and suffering.

I am NOT trying to play "gotcha" games or trying to blame and shame anyone. I know how hard it is to engage and help someone who doesn't think that they are sick. I was truly trying to follow the process and create a shared learning experience and partner with all responsible for helping this young woman.

I hope that the BOS can go beyond the recommendations made my RDA and signal the need to improve the process immediately. We can't wait another 6 months.

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