FAMILY & HUMAN SERVICES COMMITTEE

December 3, 2018
10:30 A.M.
651 Pine Street, Room 101, Martinez

Supervisor Candace Andersen, Chair
Supervisor John Gioia, Vice Chair

Present: Chair Candace Andersen; Vice Chair John Gioia

Staff Present: Julie DiMaggio Enea, Senior Deputy County Administrator

Attendees: Jennifer Grand-Lejano, PH Tobacco Prev; Ruth and Larry Goldenberg; Katie Wilbur; Alicia Austin-Townsend; Susan Horrocks; Charles Madison; Sharon Madison; Roberta Chambers, RDA; L Hallen; Kathy Kelly, EHSD; Wendy Therrian, EHSD; Kathy Gallagher, EHS Director; Anthony Macias, EHSD; Lauren Rettagliata; Tim Callaghan; Jill Ray, BOS District II Representative; Laura Otis-Miles, HSD-MH; Rich Penska, HSD_MH; Brian Vanderlind, CCCSO; Alicia Silva, MHCS; Dan McClelland, Forensic MH; Cedrita Claiborne, HSD Public Health; Thomas Anderson; Gigi Crowder; Jan and Tony Khalil; Mark Cohen; Marc Scannell, HSD MH; Jan Cobaleda-Kegler, HSD-BH; Matthew White, HSD BH; Douglas Dunn; Carly Finkle; Mariana Moore; Caitlin Sly; Larry Sly; Bob Uyeki; Becky Gershon; Ardavan Davaran; Amy Cole; Windy Taylor, HSD BH; Warren Hayes, HSD BH; Lauren Hansen; Teresa Pasquini; Don Green; Sarah Kennard; Ms. Dandie; Bill and Trisha Green

1. Introductions

   Due to the large attendance, the meeting was relocated to Room 101 and convened at 12:00 noon.

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

   No one requested to speak during the public comment period.

3. RECEIVE and APPROVE the draft Record of Action for the October 22, 2018 Family & Human Services Committee meeting.

   The Committee approved the minutes of the October 22, 2018 FHS meeting as presented.

   AYE: Chair Candace Andersen, Vice Chair John Gioia

   Passed

4. ACCEPT follow-up report from the Employment and Human Services Director in response to CalFresh Partnership recommendations pertaining to wait times experienced by CalFresh clients.

Wendy Therrian presented the staff report.

Mariana Moore expressed frustration about the long wait times for food stamps. She acknowledged the department's efforts but said more should be done to reduce wait times and that a bolder response is needed. She requested an estimate of the number of staff that would be needed to address the problem.

Larry Sly expressed concern about the additional workload associated with the "tsunami of people" that will be wanting services due to pending SSI changes. He wanted to know how the County was preparing for this workload spike. He opined that the County's Single Audit report is incomprehensible and not a good substitute for clear department reporting or an independent analysis. He stated that he was requesting only a one-time funding allocation.

Kathy Gallagher responded that not all who are eligible for SSI will actually apply, and that Mathematica (policy research) makes estimates at the state level. She noted that these estimates have no relation to the state dollar allocation to the County. She acknowledged that there is a tight window during which to hire and train staff. EHS plans to hire in January, as applications will be accepted in May, to be effective June 1. She consented to having an independent analysis conducted if private funding were made available to fund such an analysis.

Community organization representatives commented that the strategies necessary to expedite the process such as flexible interviews and telephone signatures, will require additional staff, and that the homeless and mentally ill are unable to complete the benefits applications nor can they store/file the information.

Gigi Crawford suggested drop-in sites vs. telephone interviews and suggested that new staff training include curriculum on mentally ill recipients.

Carly Finkle suggested that staff need to be trained by May 1 and that the State's estimate was an additional 10,000 applicants, a 33% increase over the County's current workload.

Supervisor Gioia acknowledged that in lieu of lifting the hiring freeze, EHS is reassigning staff internally to address workload shifts. He suggested starting the hiring process early in anticipation of the SSI changes. He acknowledged the needs and explained that the County Budget is a zero-sum exercise and the Board has the challenge of balancing all of the County's needs within the limited resources available. He described some of the other critical County needs, including the need to curtail staff turnover occurring due to hard-to-afford employee health benefits.

The Committee accepted the staff report with direction to the EHS Director to report back again next year.

AYE: Chair Candace Andersen, Vice Chair John Gioia

Passed

5. RECOMMEND to the Board of Supervisors the appointment of Jill Kleiner to At Large #19 seat with a term expiring September 30, 2019, and Steve Lipson to At Large #6 seat, and Jatin Mehta to At Large #8 seat with terms expiring September 30, 2020, on the Advisory Council on Aging, as recommended by the Council.

The Committee approved the appointment of Jill Kleiner to At Large #19 seat with a term expiring September 30, 2019, and Steve Lipson to At Large #6 seat, and Jatin Mehta to At Large #8 seat with terms expiring September 30, 2020, on the Advisory Council on Aging and directed staff to forward the recommendations to the Board of Supervisors.

AYE: Chair Candace Andersen, Vice Chair John Gioia

Passed

6. ACCEPT the annual report from the Public Health Division of the Health Services Department on the implementation of the Secondhand Smoke Protections Ordinance and DIRECT staff to forward the report to the Board of Supervisors for their information.

DIRECT staff to provide another update on the Secondhand Smoke Protections Ordinance to the Family and Human Services Committee in 2019.

Dan Peddycord and Jen Grand presented the staff report. The Committee accepted the report and directed staff to send a letter to each City Manager inviting them to model their own city ordinances after the County's ordinance.

AYE: Chair Candace Andersen, Vice Chair John Gioia

Passed

7. ACCEPT the annual report from the Public Health Department on the implementation of the Tobacco Retailer Licensing and Businesses Ordinances and DIRECT staff to forward the report to the Board of Supervisors for their information.

DIRECT staff to report back to the Family and Human Services Committee in 2019.

Dan Peddycord presented the staff report, citing 74% compliance with pack and flavor restrictions based on a spot check of stores. He noted that Senator Glazer has introduced a bill to prohibit flavored tobacco and that many other jurisdictions have established local ordinances doing so.

The Committee accepted the staff report and directed staff to provide another status report in six months.

AYE: Chair Candace Andersen, Vice Chair John Gioia

Passed

8. CONSIDER accepting the cumulative evaluation report from the Health Services Department on the implementation of Laura's Law – Assisted Outpatient Treatment (AOT) program during the period February 2016 through June 2018, and

CONSIDER recommending to the Board of Supervisors that the AOT Program be extended beyond the previously authorized three-year pilot period as part of Contra Costa Behavioral Health Services' ongoing service delivery for persons experiencing serious mental illness.

Fiscal Impact (if any):
Actual expenditures for FY 17/18: Funding Source:
CCBHS - $1,812,919 Mental Health Services Act
County Counsel - 32,379 County General Fund
Public Defender - 56,250 County General Fund
Superior Court - 2,585 County General Fund
$1,904,133

Funds are budgeted for the CCBHS portion of the AOT Program for the balance of FY 2018/19, and MHSA revenue is expected to sustain the CCBHS portion of the program costs for the fiscal years 2020-23.

Dr. Matt White introduced Roberta Chambers of RDA, who presented the cumulative AOT Program evaluation report for the period February 2016 through June 2018. The main findings reported were that the program cost less than expected, enrollees are receiving a high degree of service, and that court-involved participants received less service than voluntary participants. She reported that 13/70 participants were homeless and that the program coordinates and trains with police, the CORE Team, H3 and County Mental Health to link qualified requestors with the program.

Warren Hayes commented that there are 20 scattered housing sites/slots available to the program. Rich Penksa commented that eligibility for these housing slots requires enrollment in AOT.

Douglas Dunn commented that County Counsel was too restrictive and that judicial petition is underused. He expressed concern that premature discharge of enrollees led to relapse.

Lauren Rettagliata commented that we have ACT but no judicial element (AOT). She suggested that the judge needs to meet quarterly and establish a bond of trust with the mentally ill person. She said that the judge should become like the mentally ill person's advocate. She also identified a communication gap in that the 4C hearing officer is routinely not aware if an individual was dismissed from AOT.

Teresa Pasquini express gratitude for the program but concurred with the comments made by others.

Bill Green suggested setting up a group to study easing program restrictions because the program is underutilized.

Alicia Austin-Townsend commented that MH is not actually discharging, but has identified a few individuals for judicial intervention -- ACT first, and then determine if AOT is warranted.

Supervisor Gioia advised that implementation issues were better discussed at AOT workgroup meetings. The Committee accepted the evaluation report and decided to recommend to the Board of Supervisors continuation of the AOT Program beyond the three-year pilot authorization.

AYE: Chair Candace Andersen, Vice Chair John Gioia

Passed

9. This is the final meeting of the 2018 Committee. No further meetings are scheduled.

10. Adjourn

Chair Andersen adjourned the meeting at 2:10 p.m.

For Additional Information Contact:

Julie DiMaggio Enea, Interim Committee Staff
Phone (925) 335-1077, Fax (925) 646-1353
julie.enea@cao.cccounty.us

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FAMILY AND HUMAN SERVICES COMMITTEE

RECORD OF ACTION FOR OCTOBER 22, 2018

Supervisor Candace Andersen, Chair
Supervisor John Gioia, Vice Chair

Present: Candace Andersen, Chair
John Gioia, Vice Chair

Staff Present: Timothy Ewell, Chief Asst. County Administrator

Attendees: Julia Taylor, County Admin Office
Kathy Gallagher, EHS Director
Victoria Tolbert, EHSD
Camilla Rand, EHSD
Juliana Mondragon, EHSD
Members, SEIU, Local 1021
Members, Local 21

DRAFT

1. Introductions

   Chair Andersen convened the meeting at 10:35 a.m. and self-introductions were made around the room.

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

   The Committee accepted public comment. Four Speakers: One regarding Local 21, and three regarding SEIU 1021, all addressed the issues of high health insurance costs for Contra Costa County employees and high caseloads.

3. RECEIVE and APPROVE the draft Record of Action for the September 24, 2018 Family & Human Services Committee meeting.

   The Committee approved the Record of Action for the September 24, 2018 meeting as presented.

   AYE: Chair Candace Andersen, Vice Chair John Gioia
   Passed

4. RECOMMEND to the Board of Supervisors the appointment of Olga Jones to the At Large 5 seat on the Family and Children's Trust Committee to a new term that will expire on September 30, 2020.

The Committee approved the appointment of Olga Jones to the At Large 5 seat on the Family and Children's Trust Committee to a term that will expire on September 30, 2020, and directed staff to forward the recommendation to the Board of Supervisors.

AYE: Chair Candace Andersen, Vice Chair John Gioia

Passed

5. RECOMMEND to the Board of Supervisors the appointment of Joan M. D'Onofrio to the At Large 3 seat and Lanita L. Mims to the At Large 4 seat on the Arts and Culture Commission of Contra Costa County (AC5), as recommended by AC5.

The Committee approved the appointment of Joan M. D'Onofrio to the At Large 3 seat and Lanita L. Mims to the At Large 4 seat on the Arts and Culture Commission (AC5) to terms that will expire on June 30, 2021, and directed staff to forward the recommendation to the Board of Supervisors.

AYE: Chair Candace Andersen, Vice Chair John Gioia

Passed

DRAFT

6. ACCEPT the report from the Employment and Human Services Department on aging and adult services, including the progress made to address the issue of elder abuse in Contra Costa County.

Employment and Human Services Department, Aging and Adult Services Director, Victoria Tolbert, presented the report. Ms. Tolbert reported that the two major challenges facing the aging population are housing insecurity and poverty. Ms. Tolbert explained that Aging and Adult Services offers a continuum of services that address a range of needs. Examples of services include putting safety features in the home, a Whole Person Care program for individuals with significant medical issues, adult protective services, and "no wrong door".

Supervisor Andersen asked what number people should call for support: It is 1-800-510-2020. Ms. Tolbert reported that awareness of this number has increased. Supervisor Andersen supported increasing awareness of this number.

An internal challenge to the Department that Ms. Tolbert reported on was the shortage of direct services staff, particularly social workers and in-home support services staff. She indicated that it is a priority with Kathy Gallagher, David Twa and Human Resources. Also, the Department is working on placing more energy into staff development to internally build the needed knowledge and skill sets.

Aging and Adult Services is working to identify non-licensed facilities and help them achieve licensing to increase supply. An option discussed was creating a County certification, so if they cannot obtain a state license, they come out of the

shadows and have some oversight.

Another issue discussed was hospital discharges lacking safe locations to which to discharge. Aging and Adult Services coordinates with discharge planners and hospitals to coordinate safe discharges. Possible legislation would ban hospital discharges to shelters without an available bed. Senior specific shelters would help to close the capacity gap.

The department made a final request for the Board of Supervisors to engage in supporting and spreading awareness about these services.

AYE: Chair Candace Andersen, Vice Chair John Gioia

Passed

7. ACCEPT the report from the Employment and Human Services Department on the oversight and activities of the Community Services Bureau.

Employment and Human Services Department, Community Services Bureau Director Camilla Rand presented the report. One item reported on was the closing of one Richmond child service facility and seeking relocation for the Central Kitchen. The Kitchen currently produces about 40,000 meals each month.

A positive legislative change discussed was the consolidation of childcare license to requiring one for ages 0 to 5.

DRAFT

An internal challenge to the Department that Victoria Tolbert reported on was the shortage of staff. One tactic for addressing the staff shortage is additional staff development through a Teacher Apprenticeship program.

Ms. Rand notified Supervisor Andersen that three reviews are expected this year, and they will want to interview the Board of Supervisors. The Board will need to be versed in programmatic details.

AYE: Chair Candace Andersen, Vice Chair John Gioia

Passed

8. ACCEPT report from the Employment and Human Services Director on the Department's use of technology to support client services and staff efficiencies.

Employment and Human Services Department, Administrative Services Director Michael Roetzer presented the report. Mr. Roetzer reported on some of the technological advancements EHSD has made, including: video conferencing for American Sign Language customers, redesigning the website, expanding video conferencing in lieu of in-person or over the phone for increased efficiency and effectiveness, using electronic signatures on certain forms, getting mobile devices to more in-home supportive services staff, and encouraging clients to use My Benefits in CalWIN for case updates.

AYE: Chair Candace Andersen, Vice Chair John Gioia

Passed

9. The November 26, 2018 FHS Committee meeting is canceled due to schedule conflicts. The date for the final 2018 meeting is yet to be determined.

   The final FHS Committee meeting has been scheduled for Monday, December 3, 2018 at 9:00 a.m. in Room 101.

10. Adjourn

DRAFT

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CONTRA COSTA COUNTY
EMPLOYMENT & HUMAN SERVICES

MEMORANDUM

Kathy Gallagher, Director

40 Douglas Drive, Martinez, CA 94553 • (925) 608 5000 • Fax (925) 313-9748 • www.ehsd.org

To:
- Family and Human Services Committee
- Contra Costa County Board of Supervisors

Date: December 3, 2018

From:
- Kathy Gallagher, Department Director
- Wendy Therrian, Workforce Services Director
- Rebecca Darnell, Workforce Services Deputy Director
- Kathi Kelly, CalFresh Policy Manager

Subject: **FOLLOW-UP: CALFRESH PROGRAM UPDATE**

I. Overview – Inquiries/Requests and Responses

For your Committee meeting on September 24, 2018, a comprehensive report on our CalFresh program had been submitted for review and discussion. During the September 24th discussion your Committee and Community Partners raised the following primary issues, concerns, and questions on which to report back.

A. Committee Members

1. Community Outreach especially with the Re-entry population

Response:

We continually endeavor to expand and strengthen outreach to potential CalFresh recipients especially to more disenfranchised groups such as the re-entry population. Our community partners regularly conduct outreach at County Parolee Education meetings as well as partner with several "No Wrong Door" reentry services. Conversations are planned to be held with the West County Reentry Services Center through the Food Bank of Contra Costa and Solano to provide for this coordination.

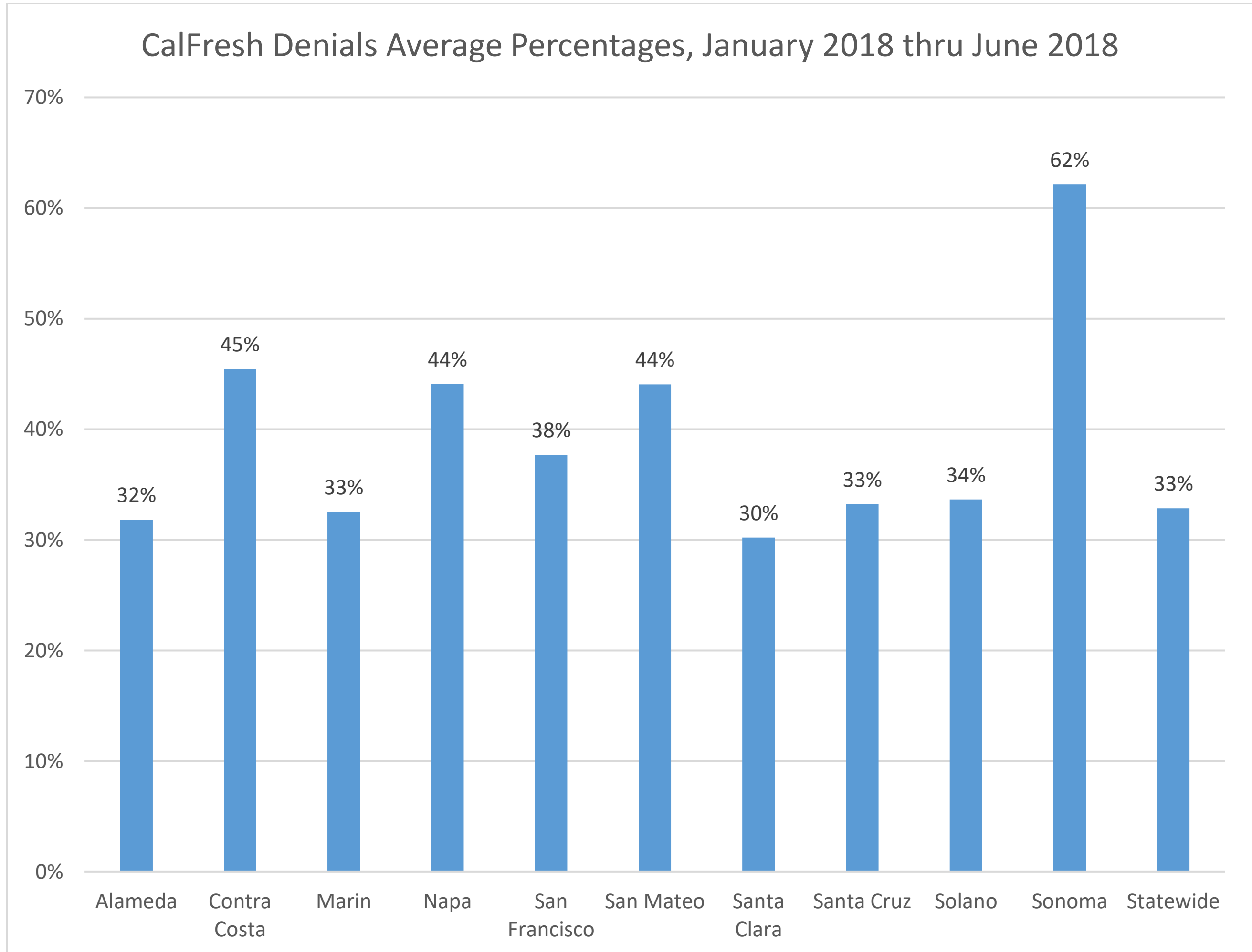
In addition, we are hopeful to have funded through AB 109 a Re-Entry Coordinator position which will increase access and services coordination for all EHSD programs targeting the County's reentry population.

The WFS Bureau is also currently planning to have an Eligibility Worker assigned on a rotational, part-time basis to the West County Reentry Services Center. This is planned similarly to the assignment and connection planned with Lovonya Dejean Middle School.

2. The denial rate and reasons for denials of CalFresh applications

Response:

Our current denial rate is 45% (from January 1 through June 2018). The chart below compares our denial rates with those of other counties in the Bay Area.



The top two reasons for denials are participants not keeping scheduled interview appointments, and failure to provide verifications. These are the same primary two reasons the Food Bank of Contra Costa and Solano experiences.

Additionally, applicants (particularly those making on-line applications) have reported not being aware interviews are required and then do not follow through with the entire application process. Other applicants generally feel we are "too much in their business" and decide not to continue with the eligibility process.

Currently the Department is exploring ways to better ensure CalFresh recipients are aware of interview requirements. We are also planning for new and continuous CalFresh verification training to ensure our workers understand necessary verifications to grant

eligibility. Additionally, and in conjunction with other counties, we are exploring other best practices to minimize denials. For example, we know of one county who has a dedicated clerical pool which continually reaches out to applicants to explain what is needed to determinate eligibility and then provides for direct, "warm hand-offs" to Eligibility Workers.

3. The number of those eligible, but not participating in the CalFresh program

***Response**:*

According to the California Department of Social Services website and using their most current information for 2016 under the Program Reach Index (PRI) (which estimates the CalFresh utilization among those individuals estimated to meet CalFresh eligibility requirements based on the U.S. Census), there are an estimated 40,000 persons who are not being served in the County.

However, these estimates are frequently questioned given the population counted in the Census who are not necessarily eligible, or who are known to be reluctant to apply even if they are under the income threshold (130% FPL). The reasons for this are listed below.

- **Ineligible***:*

  a. *Undocumented immigrants*

  b. *Residents receiving federal Supplement Security Income (SSI) benefits (approximately 26,000 in Contra Costa County) are ineligible for CalFresh benefits and are typically under the income threshold. These individuals will become CalFresh eligible on June 1, 2019 with the implementation of the new SSI Cash-Out policy change.*

- **Eligible, but report the following reasons for not applying:**

  a. *Seniors who feel they are taking the benefit away from others who may need it more*

  b. *Perceived stigma of being a Food Stamp (CalFresh) recipient*

  c. *Students and Seniors report the benefit amount is so small ($10.00 to $25.00) that it is not worth their time to apply*

  d. *Students report the process of maintaining their benefits is confusing and cumbersome.*

However, with the implementation of the new SSI Cash-Out program we expect additional County residents to be reached. And, under the new Able-Bodied Adults without Dependents (ABAWD) program, our objective and that of our CalFresh community partners is to preserve the eligibility of those existing CalFresh households through the use of exemption criteria as well as assistance with meeting the work requirements.

4. A copy of the Department's Public Charge announcement

Response:

A link to the text of the proposed Public Charge rules and the accompanying press release was sent to the FHS Committee on September 24, 2018. The Department's Public Briefing document on Public Charge can be found at https://ehsd.org/2018/10/09/proposed-public-charge-rule-changes-signal-chilling-effect-on-benefit-programs/.

And, as your Committee is aware, your Board took action on October 23, 2018 to amend the County's 2018 Federal Legislative Platform to include your opposition to proposed regulatory changes on public charge.

At the September 24, 2018 FHS meeting the following three recommendations were offered by the CalFresh Partnership Group to be brought back at a later FHS meeting.

B. Community Partners

1. *"Lift the hiring freeze on the Workforce Services Bureau so they can hire more frontline CalFresh staff."*

Response:

Given our existing budget constraints, the Department is unable to lift the existing two (2) year hiring freeze for the WFS Bureau particularly given new employee costs which will be required to be incorporated and paid from existing and future allocations including CalFresh. However, in order to align our individual allocations for Medi-Cal, CalFresh, and CalWORKs in the current program year, we are planning to move fifteen (15) Eligibility Workers (EWs) from CalWORKs to our Medi-Cal CalFresh Service Center (MCSC). This staff movement will contribute to decreasing the wait times at the MCSC thereby improving our services to the public in both CalFresh and Medi-Cal.

Additionally, we are expecting to receive an augmented CalFresh allocation by the end of the calendar year which is provided for the expected influx of SSI recipients who will become eligible to CalFresh under the new SSI Cash-Out rule. We are planning to operationalize this new requirement effective June 1, 2019.

Once we know the amount of the augmented CalFresh allocation, we will more specifically determine the number of additional eligibility staff needed to process and carry these special cases.

In the meantime, we are estimating the number of SSI recipients who are likely to apply for CalFresh to make the initial determination of how many additional CalFresh workers we

will need come June 1, 2019. This number will then be concretized at the time our augmented CalFresh allocation is known.

2. *"Commit any augmented allocation this year to fund additional front-line staff so that people can receive the customer service they need to navigate the benefits process. This request especially related to the newly eligible Supplemental Security Income (SSI) population as well as the Able Bodied Adults Without Dependents (ABAWD) waiver roll out effective September 1, 2019".*

***Response**:*

Because of the new SSI Cash-Out rule to be implemented June 1, 2019 and the new ABAWD program to be implemented September 1, 2019, it is the Department's goal to commit as many front-line and support staff as may be necessary to provide efficient and timely services to these new applicants and clients many of which are expected to be elderly and/or disabled. The staffing level will be based on both the existing and augmented CalFresh allocations the latter of which is not yet known (as of the writing of this report).

We are currently planning to provide easy access and coordination amongst our two primary Bureaus – Workforce Services, and Adult and Aging Services to serve the existing and new CalFresh population.

3. *"In reference to customer service, access to benefits, and fighting hunger; create transparency about where the resources for the CalFresh allocation are being used within the County to ensure the best use of taxpayer dollars. To do so, engage an independent contractor to conduct an impartial analysis of how CalFresh and other public benefits administrative dollars are allocated, and share CalFresh and other public benefits administrative dollars are allocated, and share the results with the public."*

***Response**:*

The CalFresh program locally administered by the County Employment and Human Services Department (EHSD) is subject to and included under the County's Single Audit financial reviews. The outcome of these reviews are included in the Comprehensive Annual Financial Reports (CAFRs) and are available on-line via the County Auditor's website. The responsibility for these financial reviews fall under the auspices of the Office of the County Auditor-Controller and are conducted by independent CPA firms.

The manner in which these financial reviews are conducted and published allow for maximum transparency into the Department's operation and use of all allocations and funding sources.

Typically, twelve (12) to fifteen (15) percent of all primary EHSD funding allocations (including CalFresh) are earmarked for both administrative and operational support with the remainder supporting direct operations and services.

For the above reasons, we believe an additional and outside audit expenditure related to this suggestion is unnecessary with the financial review being duplicative.

II. Updated Review of Major Upcoming Legislation affecting CalFresh

A. Able Bodied without Dependents (ABAWD) Program

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) limits the receipt of CalFresh benefits to three months in a 36-month period for the Able Bodied without Dependents (ABAWD) CalFresh population if they are not working: participating at least 80 hours per month in a qualifying education or training activity; participating in a workfare program or exempt due to age; caring for a child or incapacitated household member; or certified as medically unfit for employment.

Previously, there was a waiver to this requirement which was expected to end August 31, 2018, and with the exception of three (3) counties (San Francisco, San Mateo, and Santa Clara) was extended to August 31, 2019 for the remainder of California counties including Contra Costa. However, we recently were notified by the California Department of Social Services (CDSS) that we are now one of three additional counties who will be subject to this requirement with the end of the waiver for us on August 31, 2019. Consequently, we will be required to implement effective September 1, 2019. When this occurs, ABAWDs who do not meet exemption criteria will be required to participate in work activities in order to continue to receive benefits.

The implementation of ABAWD exemptions and work requirements is a major emphasis of the Bureau and Community Partners at this time.

In partnership with EHSD, the Food Bank of Contra Costa and Solano has secured significant private funding from four local foundations to tackle this issue. EHSD has engaged in this new partnership, specifically focused on mitigating the negative effects of the ABAWD roll-out and ensuring adequate supports for work in the community. This project has involved contracting with the Glen Price Group consulting firm to convene necessary stakeholders and to leverage partnerships to create a community-wide response to this impending challenge.

B. Supplemental Security Income and/or California State Supplementary Payment (SSI/SSP) Cash-Out Policy

Effective June 1, 2019 individuals receiving or authorized to receive SSI/SSP are now eligible for CalFresh, providing all other eligibility criteria are met.

This policy changes California's "Cash-Out" policy that began in 1974 when it opted to increase the monthly SSP allotment by $10 instead of administering food benefits to SSI/SSP recipients. Two state funded programs will also be created to provide benefits to continuing households that will have their monthly benefits reduced or discontinued due to

adding a previously excluded SSI/SSP individual.

This is another primary planning and implementation project for the Department and our Community Partners.

III. Important Next Steps

The Department remains committed to providing timely and ready access to CalFresh benefits for those with unmet food needs, and in continuing to serve our CalFresh customers in a timely and accurate manner. We have a continual improvement objective in the areas of outreach, access, enrollment, and services delivery.

Part of this objective is to continue our community outreach efforts and to work even more closely with our community partners to expand access to CalFresh benefits. Expanding access includes our continued rollout of electronic and other alternative means for applying for benefits despite our staffing reductions. We will also continue our efforts to further streamline our CalFresh application and benefits renewal process, and will continue to work on increasing knowledge and awareness of the CalFresh program and the application process throughout and to targeted areas within the County.

In coordination with our CalFresh Partners, this awareness campaign will include the impacts and implementation of the new SSI Cash-Out and ABAWD programs which will be closely monitored to ensure ready access, efficient services, and continued eligibility.

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Contra Costa County California
Employment & Human Services

Kathy Gallagher, Director
40 Douglas Dr., Martinez, CA 94553 ✶ Phone: (925) 313-1579 ✶ Fax: (925) 313-1575 ✶ www.cccounty.us/ehsd.

MEMORANDUM

DATE: 11/21/2018

TO: Family and Human Services Committee

CC: Victoria Tolbert, Director Aging and Adult Services

FROM: Anthony Macias, Staff Representative for the Advisory Council on Aging

SUBJECT: Advisory Council on Aging – Appointment Requested

The Contra Costa Area Agency on Aging (AAA) recommends for immediate appointment to the Contra Costa Advisory Council on Aging (ACOA) the following applicant: Ms. Jill Kleiner for Member at Large Seat # 19. The MAL #19 seat is undesignated and has remained vacant since March 20, 2018.

Recruitment has been handled by both the Area Agency on Aging, the ACOA and the Clerk of the Board using CCTV. AAA staff has encouraged interested individuals including minorities to apply through announcements provided at the Senior Coalition meetings and at the regular monthly meetings of the ACOA. The Contra Costa County EHSD website contains dedicated web content where interested members of the public are encouraged to apply and are provided an application with instructions on whom to contact for ACOA related inquiries, including application procedure.

Ms. Kleiner was interviewed by the ACOA Membership Committee on 8/15/18 to fill MAL #19 on the ACOA with term ending 9/30/2019. Ms. Kleiner submitted an application for ACOA membership dated 6/23/2018 that is provided as a separate attachment. The ACOA voted to approve Ms. Kleiner's appointment recommendation at their 9/19/18 meeting.

Thank You

Application Form

Profile

Which Boards would you like to apply for?

Advisory Council on Aging: Submitted

Seat Name (if applicable)

Describe why you are interested in serving on this advisory board/commission (please limit your response to one paragraph).

Having recently retired from a 30+ year career as a Retirement Plan consultant to Fortune 500 companies as well as volunteering 20+ years for the Western Pension and Benefits Council, including being president of their governing board of 11 chapters, I'm thrilled to have time to become more involved in my community.

This application is used for all boards and commissions

Jill
First Name

M
Middle Initial

Kleiner
Last Name

[redacted]
Email Address

[redacted]
Home Address

Suite or Apt

Moraga
City

CA
State

[redacted]
Postal Code

[redacted]
Primary Phone

N/A - Retired 1/2/18
Employer

Job Title

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

Education History

Select the highest level of education you have received:

☑ Other

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

College/ University A

UC Berkeley
Name of College Attended

Statistics
Course of Study / Major

enough for degree
Units Completed

Type of Units Completed

☑ Quarter

Degree Awarded?

◉ Yes ○ No

BA
Degree Type

1985
Date Degree Awarded

College/ University B

Name of College Attended

Course of Study / Major

Units Completed

Type of Units Completed

None Selected

Degree Awarded?

○ Yes ○ No

Degree Type

Date Degree Awarded

College/ University C

Name of College Attended

Course of Study / Major

Units Completed

Type of Units Completed

None Selected

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)

3/5/2001-1/2/18
Dates (Month, Day, Year) From - To

40
Hours per Week Worked?

Volunteer Work?

○ Yes ◉ No

Senior Retirement Consultant
Position Title

Employer's Name and Address

Willis Towers Watson 345 California Street San Francisco, CA 94104

Duties Performed

Recently retired after a 30+ career in the retirement field. Consulted with fortune 500 and larger employers on their Defined Contribution Plans (401(k), 403(b), nonqualified plans, etc), including plan design, vendor selection, governance, compliance, and regulatory/legislative updates and trends.

2nd

7/1/14-7/1/15
Dates (Month, Day, Year) From - To

varies
Hours per Week Worked?

Volunteer Work?

(•) Yes ( ) No

President of Governing Board
Position Title

Employer's Name and Address

Western Pension and Benefits Council - Governing Board of 11 chapters across the west

Duties Performed

Member of the Western Pension and Benefits Council over 20+ years performing various duties from being on committees to chairing San Francisco Chapter Program Committee and Spring Conference to Board Member at Large to Board Treasurer to VP and then President of SF chapter. Once SF VP level also joined Governing board of 11 chapters, with roles of secretary, VP marketing, & finally President of Gov Board.

3rd

1996-2001
Dates (Month, Day, Year) From - To

40
Hours per Week Worked?

Volunteer Work?

○ Yes ◉ No

Director
Position Title

Employer's Name and Address

PriceWaterhouseCoopers 333 Market Street San Francisco, CA

Duties Performed

Defined contribution retirement plan relationship manager for clients and managed outsourcing teams. Responsible for selling and retaining clients as well as developing colleagues.

Upload a Resume

Final Questions

How did you learn about this vacancy?

☑ Newspaper Advertisement

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:

Contra Costa County California
Employment & Human Services

Kathy Gallagher, Director
40 Douglas Dr., Martinez, CA 94553 ✶ Phone: (925) 313-1579 ✶ Fax: (925) 313-1575 ✶ www.cccounty.us/ehsd.

MEMORANDUM

DATE: 11/20/2018

TO: Family and Human Services Committee

CC: Victoria Tolbert, Director Aging and Adult Services

FROM: Anthony Macias, Staff Representative for the Advisory Council on Aging

SUBJECT: Advisory Council on Aging – Appointment Requested

The Contra Costa Area Agency on Aging (AAA) recommends for immediate appointment to the Contra Costa Advisory Council on Aging (ACOA) the following applicant: Mr. Jatin Mehta for Member at Large Seat # 8. The MAL #8 seat is undesignated and has remained vacant since July 10, 2018.

Recruitment has been handled by both the Area Agency on Aging, the ACOA and the Clerk of the Board using CCTV. AAA staff has encouraged interested individuals including minorities to apply through announcements provided at the Senior Coalition meetings and at the regular monthly meetings of the ACOA. The Contra Costa County EHSD website contains dedicated web content where interested members of the public are encouraged to apply and are provided an application with instructions on whom to contact for ACOA related inquiries, including application procedure.

Mr. Mehta was interviewed by the ACOA Membership Committee on 8/15/18 to fill MAL #8 on the ACOA with term ending 9/30/2020. Mr. Mehta submitted an application for ACOA membership dated 6/10/2018 that is provided as a separate attachment. The ACOA voted to approve Mr. Mehta's appointment recommendation at their 9/19/18 meeting.

Thank You

Print Form

Contra Costa County

For Office Use Only
Date Received:

For Reviewers Use Only:
Accepted Rejected

RE[illegible]D
JUN 15 2018
CLERK BOARD OF SUPERVISORS
CONTRA COSTA CO.

BOARDS, COMMITTEES, AND COMMISSIONS APPLICATION

MAIL OR DELIVER TO:
Contra Costa County
CLERK OF THE BOARD
651 Pine Street, Rm. 106
Martinez, California 94553-1292
PLEASE TYPE OR PRINT IN INK
(Each Position Requires a Separate Application)

BOARD, COMMITTEE OR COMMISSION NAME AND SEAT TITLE YOU ARE APPLYING FOR:

ADVISORY COUNCIL ON AGING
PRINT EXACT NAME OF BOARD, COMMITTEE, OR COMMISSION

AT-LARGE SEAT MEMBER
PRINT EXACT SEAT NAME (if applicable)

1. **Name:** MEHTA (Last Name) JATIN (First Name) K (Middle Name)

2. **Address:** (No.) (Street) (Apt.) BRENTWOOD (City) (State) (Zip Code)

3. **Phones:** (Home No.) (Work No.) (Cell No.)

4. **Email Address:**

5. **EDUCATION**: Check appropriate box if you possess one of the following:

High School Diploma ☐ G.E.D. Certificate ☐ California High School Proficiency Certificate ☐

Give Highest Grade or Educational Level Achieved MASTERS

	Names of colleges / universities attended	Course of Study / Major	Degree Awarded	Units Completed: Semester	Units Completed: Quarter	Degree Type	Date Degree Awarded
A)	The University of Toledo, OH	M.S in Pharmaceutical Sciences	(Yes) No ☒☐	43		M.S.	5/10/03
B)	The University of Pune, India	M.S in Pharmacy (Pharmacology)	(Yes) No ☐☐	36		M.S	12/1999
C)	Shivaji University India	Pharmacy	(Yes) No ☐☐	136		B. Pharmacy	1/27/1997

D) Other schools / training completed:	Course Studied	Hours Completed	Certificate Awarded:
			Yes No ☐☐

THIS FORM IS A PUBLIC DOCUMENT

6. **PLEASE FILL OUT THE FOLLOWING SECTION COMPLETELY. List experience that relates to the qualifications needed to serve on the local appointive body. Begin with your most recent experience. A resume or other supporting documentation may be attached but it may not be used as a substitute for completing this section.**

Dates (Month, Day, Year)	Title / Employer's Name and Address	Duties Performed
A) From: ~~12/10/03~~ 9/13 To: Present Total: Yrs. ~~0~~4 Mos. ~~8~~ 9 Hrs. per week 40. Volunteer ☐	**Title:** PHARMACY MANAGER **Employer's Name and Address:** RITE AID 20 E. 18th ST. ANTIOCH, CA - 94509	- Dispenising prescriptions - Consulting customers on health conditions & proper usage of medications. - Immunizations. - Compliance with federal, state & local laws.
B) From: 08/2008 To: 08/13 Total: Yrs. 5 Mos. Hrs. per week 40. Volunteer ☐	**Title:** PHARMACIST **Employer's Name and Address:** RITE AID 4100 LONE TREE WAY ANTIOCH, CA	SAME AS DESCRIBED ABOVE
C) From: 12/10/03 To: 7/2008 Total: Yrs. 4 Mos. 7 Hrs. per week 40. Volunteer ☐	**Title:** PHARMACIST **Employer's Name and Address:** RITE AID ~~OH~~ CLEVELAND, TN	SAME AS DESCRIBED ABOVE
D) From: To: Total: Yrs. Mos. Hrs. per week . Volunteer ☐	**Title:** **Employer's Name and Address:**	

7. **How did you learn about this vacancy?**

☐ **CCC Homepage** ☐ **Walk-In** ☐ **Newspaper Advertisement** ☐ **District Supervisor** ☒ **Other** AAA representative Ms. Jaime Ray

8. **Do you have a Familial or Financial Relationship with a member of the Board of Supervisors? (Please see Board Resolution no. 2011/55, attached): No** ☒ **Yes** ☐

   If Yes, please identify the nature of the relationship: ______

9. **Do you have any financial relationships with the County such as grants, contracts, or other economic relations?**
   No ☒ **Yes** ☐

   If Yes, please identify the nature of the relationship: ______

I CERTIFY that the statements made by me in this application are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I acknowledge and understand that all information in this application is publically accessible. I understand and agree that misstatements / omissions of material fact may cause forfeiture of my rights to serve on a Board, Committee, or Commission in Contra Costa County.

Sign Name: ______ **Date**: 6/10/18

Important Information

1. This application is a public document and is subject to the California Public Records Act (CA Gov. Code §6250-6270).
2. Send the completed paper application to the Office of the Clerk of the Board at: **651 Pine Street, Room 106, Martinez, CA 94553**.
3. A résumé or other relevant information may be submitted with this application.
4. All members are required to take the following training: 1) The Brown Act, 2) The Better Government Ordinance, and 3) Ethics Training.
5. Members of boards, commissions, and committees may be required to: 1) file a Statement of Economic Interest Form also known as a Form 700, and 2) complete the State Ethics Training Course as required by AB 1234.
6. Advisory body meetings may be held in various locations and some locations may not be accessible by public transportation.
7. Meeting dates and times are subject to change and may occur up to two days per month.
8. Some boards, committees, or commissions may assign members to subcommittees or work groups which may require an additional commitment of time.

Contra Costa County California
Employment & Human Services

Kathy Gallagher, Director
40 Douglas Dr., Martinez, CA 94553 ✶ Phone: (925) 313-1579 ✶ Fax: (925) 313-1575 ✶ www.cccounty.us/ehsd.

MEMORANDUM

DATE: 11/20/2018

TO: Family and Human Services Committee

CC: Victoria Tolbert, Director Aging and Adult Services

FROM: Anthony Macias, Staff Representative for the Advisory Council on Aging

SUBJECT: Advisory Council on Aging – Appointment Requested

The Contra Costa Area Agency on Aging (AAA) recommends for immediate appointment to the Contra Costa Advisory Council on Aging (ACOA) the following applicant: Mr. Steve Lipson for Member at Large Seat # 6. The MAL #6 seat is undesignated and has remained vacant since July 24, 2018.

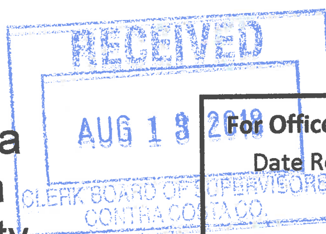
Recruitment has been handled by both the Area Agency on Aging, the ACOA and the Clerk of the Board using CCTV. AAA staff has encouraged interested individuals including minorities to apply through announcements provided at the Senior Coalition meetings and at the regular monthly meetings of the ACOA. The Contra Costa County EHSD website contains dedicated web content where interested members of the public are encouraged to apply and are provided an application with instructions on whom to contact for ACOA related inquiries, including application procedure.

Mr. Lipson was interviewed by the ACOA Membership Committee on 8/15/2018 to fill MAL #6 on the ACOA with term ending 9/30/2020. Mr. Lispson submitted an application for ACOA membership dated 8/13/2018 that is provided as a separate attachment. The ACOA voted to approve Mr. Lipson's appointment recommendation at their 9/19/2018 meeting.

Thank You

Print Form

Contra Costa County



For Office Use Only
Date Received:

For Reviewers Use Only:
Accepted Rejected

BOARDS, COMMITTEES, AND COMMISSIONS APPLICATION

MAIL OR DELIVER TO:
Contra Costa County
CLERK OF THE BOARD
651 Pine Street, Rm. 106
Martinez, California 94553-1292
PLEASE TYPE OR PRINT IN INK
(Each Position Requires a Separate Application)

BOARD, COMMITTEE OR COMMISSION NAME AND SEAT TITLE YOU ARE APPLYING FOR:

Contra Costa Advisory Council on Aging
PRINT EXACT NAME OF BOARD, COMMITTEE, OR COMMISSION

representative/member-at-large
PRINT EXACT SEAT NAME (if applicable)

1. **Name:** Lipson Steve B
(Last Name) (First Name) (Middle Name)

2. **Address:** El Cerrito.
(No.) (Street) (Apt.) (City) (State) (Zip Code)

3. **Phones:**
(Home No.) (Work No.) (Cell No.)

4. **Email Address:**

5. **EDUCATION**: Check appropriate box if you possess one of the following:

High School Diploma ☒ G.E.D. Certificate ☐ California High School Proficiency Certificate ☐

Give Highest Grade or Educational Level Achieved: BS degree, Electrical Engineering

Names of colleges / universities attended	Course of Study / Major	Degree Awarded	Units Completed: Semester	Units Completed: Quarter	Degree Type	Date Degree Awarded
A) University of Michigan	Electrical Engineering	Yes ☐ No ☒	4			
B) Wayne State University	Electrical Engineering	Yes ☒ No ☐		9	BS	1983
C)		Yes ☐ No ☐				

D) Other schools / training completed:	Course Studied	Hours Completed	Certificate Awarded:
			Yes ☐ No ☐

THIS FORM IS A PUBLIC DOCUMENT

6. **PLEASE FILL OUT THE FOLLOWING SECTION COMPLETELY. List experience that relates to the qualifications needed to serve on the local appointive body. Begin with your most recent experience. A resume or other supporting documentation may be attached but it may not be used as a substitute for completing this section.**

Dates (Month, Day, Year)	Title / Employer's Name and Address	Duties Performed
A) From: Aug 2016 To: present Total: Yrs. 2 Mos. Hrs. per week 20. Volunteer ☒	Title: Founder/Director Employer's Name and Address: ElderTech	Establish partnerships between senior centers, churches, high schools and school districts with the goal of providing older adults with one-on-one mobile technologies tutoring. Supervised intergenerational tutoring sessions, designed tutorial cirriculum, authored TechTalks.
B) From: Mch 2015 To: present Total: Yrs. 3 Mos. 3 Hrs. per week 1. Volunteer ☒	Title: committee member/Chairman Employer's Name and Address: City of E Cerrito El Cerrito Committee on Aging	15 months as a committee member examining and advocating for the needs of older adults in El Cerrito and subsequently making appropriate recommendations to City Council. Active on several subcommittees. 2 Years as Committee Chair.
C) From: Mch 2008 To: mch 2016 Total: Yrs. 8 Mos. Hrs. per week 1.5. Volunteer ☒	Title: commissioner/Vice Chair Employer's Name and Address: City of El Cerrito Park and Rec Commission	7 years as a commissioner examining and advocating for the park and rec needs of El Cerrito residents and subsequently making appropriate recommendations to City Council. Active on several subcommittees. 1 year as Commission Vice Chair.
D) From: 1999 To: Present Total: Yrs. Mos. Hrs. per week . Volunteer ☐	Title: Author/Co-Author Employer's Name and Address: Osborne/McGraw Hill Microsoft Press ElderTech Academy	Write books, articles, and collateral materials addressing the technology needs of older adults. Co-authored 2 books with Mary Furlong, founder of SeniorNet,for Microsoft Press and Osborne/McGraw Hill.

7. How did you learn about this vacancy?

[ ] CCC Homepage [ ] Walk-In [ ] Newspaper Advertisement [ ] District Supervisor [x] Other Rita Xavier

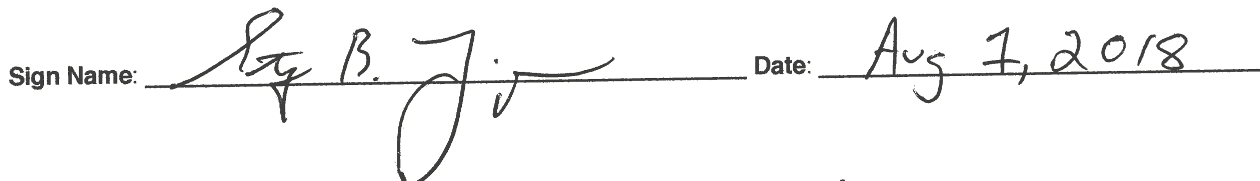
8. Do you have a Familial or Financial Relationship with a member of the Board of Supervisors? (Please see Board Resolution no. 2011/55, attached): No [x] Yes [ ]

If Yes, please identify the nature of the relationship:

9. Do you have any financial relationships with the County such as grants, contracts, or other economic relations?
No [x] Yes [ ]

If Yes, please identify the nature of the relationship:

I CERTIFY that the statements made by me in this application are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I acknowledge and understand that all information in this application is publically accessible. I understand and agree that misstatements / omissions of material fact may cause forfeiture of my rights to serve on a Board, Committee, or Commission in Contra Costa County.

Sign Name:  Date: Aug 7, 2018

Important Information

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7. Meeting dates and times are subject to change and may occur up to two days per month.
8. Some boards, committees, or commissions may assign members to subcommittees or work groups which may require an additional commitment of time.

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ANNA M. ROTH, RN, MS, MPH
HEALTH SERVICES DIRECTOR

DANIEL PEDDYCORD, RN, MPA/HA
DIRECTOR OF PUBLIC HEALTH

CONTRA COSTA
PUBLIC HEALTH
597 CENTER AVENUE, SUITE 200
MARTINEZ, CALIFORNIA 94553
PH (925) 313-6712
FAX (925) 313-6721
DANIEL.PEDDYCORD@HSD.CCCOUNTY.US

To: Family and Human Services Committee, Contra Costa Board of Supervisors
From: Daniel Peddycord, RN, MPA/HA, Director, Public Health
Re: Annual Report on Implementation of Secondhand Smoke Protections Ordinance
Date: 10/22/18

Summary

At the November 13, 2017 Family and Human Services Committee meeting, Public Health presented its annual report on the implementation of the County's Secondhand Smoke ordinance with a recommendation that the Committee consider a proposed ordinance to strengthen the current smoking protections to prohibit smoking inside dwelling units of multi-unit housing, including condos and townhomes. The Committee accepted the report and recommendations, requested that language be added to extend smoking restrictions to guest rooms of hotels and motels, and directed staff to forward to the Board of Supervisors for discussion and approval.

The ordinance, titled Smoke-free Multi Unit Residences, was adopted by the Board of Supervisors on March 13, 2018 with implementation to begin for new and renewing leases on July 1, 2018, and for continuing leases and owner-occupied units on July 1, 2019. The following report is specific to implementation of the new Smoke-free Multi-Unit Residences ordinance, including information on the continued implementation of the broader Smoke-free Secondhand Protections Ordinance.

Secondhand Smoke Ordinance Background

The Board of Supervisors adopted a comprehensive Secondhand Smoke Protections Ordinance in 2006. This decision came on the heels of the California Air Resources Board report designating secondhand smoke as a toxic air contaminant based on a review of the research linking secondhand smoke with numerous adverse health effects. The vast majority of Contra Costans do not smoke, with data showing that 13.4% of residents in the County do smoke. The Board strengthened the County's secondhand smoke protections in October 2009, October 2010, April 2013, June 2014, July 2017, and March 2018 in response to community complaints regarding drifting smoke and the need for additional policies to protect public health. These amendments to the county code included expanding secondhand smoke protections to make all County-owned properties 100% smoke-free, inclusion of electronic smoking devices in the definition of "secondhand smoke", and 100% smoke-free multi-unit housing including condos, townhomes, and guest rooms of hotels and motels.

The majority of the 161 secondhand smoke complaints received by the Public Health Department's Tobacco Prevention Program over the last three years continue to be from multi-family housing residents regarding unit-to-unit and outside-to-unit drifting smoke. For residents of the unincorporated county, staff follows up with landlords and property owners regarding compliance with the County's current laws.

Implementation of Smoke-free Multi-Unit Housing Residences since March 2018 Adoption

The Smokefree Multi-Unit Residences ordinance is implemented through the Public Health Department's Tobacco Prevention Program (TPP). Per recommendation from the California Apartment Association and as approved by the Board of Supervisors, this ordinance has a phased implementation.

Effective July 1, 2018, dwelling units with new and renewing leases were required to be smoke-free. Units with continued leases and owner occupied units are required to be entirely smoke-free as of July 1, 2019.

Notice of the newly adopted smoke-free multi-unit residence ordinance was included in the annual County Business License Office mailing in May 2018. All owners of multi-unit residences of 4 or more dwelling units must obtain a Contra Costa business license, and are recipients of the annual mailing from the County Business License Office. The mailing directed owners to the TPP Secondhand Smoke website, which was updated in June 2018 to highlight the new laws and provide resources to landlords, including signage. TPP staff wrote an article about the new laws which was included in the June 2018 newsletter sent out to members of the California Apartment Association. The County's Secondhand Smoke Protections brochure is being updated and will soon be accessible on the TPP Secondhand Smoke website. TPP staff have created a new online link for the public to report secondhand smoke complaints and request information. Once pilot tested, this link will be available on the TPP Secondhand Smoke website to facilitate a more streamlined complaint process, and standardize information received through complaints, such as the type of smoke reported (e.g., cannabis, vape, or combustible tobacco).

In preparation for the final July 1, 2019 compliance date when all multi-unit housing units, including owner-occupied are required to be 100% smoke-free, TPP staff will conduct outreach and education efforts to the community that will include a social media campaign to raise awareness about the health risks of secondhand smoke, the policies in place to protect residents, and how to make a complaint about drifting smoke in multi-unit residences. Through targeted presentations, mailings, and the TPP website, multi-unit housing owners/managers will have access to more resources to maintain compliance with smoke-free laws, including sample tenant notification letters, and sample warning letters for tenants in violation of smoke-free laws. A verification process will be conducted to ensure that all multi-unit owners and property managers have received information about the new laws and implemented new requirements such as updating all leases to include required smoke-free language and meeting required signage posting requirements.

An educational approach will be employed to address non-compliance, including working with owners/managers to assure that requirements of owners/managers under the ordinance are met, and providing technical assistance. If the owner/manager has implemented the required lease terms and signage, staff will also correspond with the tenant to educate the tenant on the law. TPP has utilized a similar approach for addressing violations of other multi-unit residence smoking restrictions under the County's ordinance, such as no smoking in common areas or near doors and windows of these buildings.

Implementation of the Smoke-free County Properties Provision and other Secondhand Smoke Protections Ordinance Provisions over the Past Year

Smoke-Free County Campuses Provision:

Tobacco Prevention Program staff continues to accept complaints about non-compliance with the County's smoke-free County Campuses law, and works with staff to address these complaints. "Smoke-free Contra Costa" signage continues to be distributed for posting to the County Building Safety Coordinators upon request. Tobacco Prevention Program staff continue to maintain the Contra Costa Smoke-Free Campus web pages on the Health Services website (www.smokefreecc.org) This includes information on the ordinance and the "Frequently Asked Questions" document for the public.

Other Ordinance Provisions and Addressing Complaints:

The Tobacco Prevention Program continues to educate the public and businesses on provisions of the ordinance through community presentations, responding to complaints and inquiries, and incorporating

materials into County business license materials. Additionally, the Tobacco Prevention Program responds to drifting smoke complaints from residents throughout the County. Outside of the Unincorporated County, the majority of secondhand smoke complaints received are from Concord, Walnut Creek, and Richmond. Staff provide resources and information to public who file complaints, as well as forward the complaint to the appropriate contact in those cities when possible.

Recommendations

Staff recommends that the Family and Human Services Committee accept the report and direct staff to continue to provide updates on implementation of the ordinance as part of staff's annual report on the County's Secondhand Smoke Protections Ordinance.

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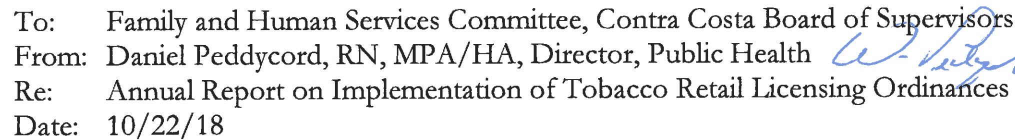
ANNA M. ROTH, RN, MS, MPH
HEALTH SERVICES DIRECTOR

DANIEL PEDDYCORD, RN, MPA/HA
DIRECTOR OF PUBLIC HEALTH



CONTRA COSTA
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PH (925) 313-6712
FAX (925) 313-6721
DANIEL.PEDDYCORD@HSD.CCCOUNTY.US

To: Family and Human Services Committee, Contra Costa Board of Supervisors
From: Daniel Peddycord, RN, MPA/HA, Director, Public Health
Re: Annual Report on Implementation of Tobacco Retail Licensing Ordinances
Date: 10/22/18

I. Summary

The Board of Supervisors approved two tobacco control ordinances in July 2017 to protect youth from tobacco influences in the retail environment: a zoning ordinance and a tobacco retailer licensing ordinance. Of particular concern were the marketing and availability of youth-friendly flavored tobacco products, small pack sizes of cigars and cigarillos, and density and location of tobacco retailers, since these contribute largely to youth exposure to tobacco influences and tobacco use. The tobacco retailer licensing ordinance required extensive preparation for implementation, and tobacco retailers were required to be compliant with the new provisions by January 1, 2018. As requested, Contra Costa Public Health staff provided a report to the Board of Supervisors in March 2018 on preliminary implementation efforts. This report provides a brief recap of those implementation efforts up to March 2018, with information on continued implementation since March as well as next steps.

II. Ordinance Provisions

Ordinance 2017-10 Tobacco Retailer Businesses (effective 8/11/17) states:

a) NEW retailers operating within 1000 feet of schools, parks, playgrounds and libraries are prohibited from selling tobacco products. Existing tobacco retailing businesses operating within 1000 feet of these areas are nonconforming uses. A nonconforming use will be allowed to continue operating under the ordinance.
b) NEW retailers within 500 feet of tobacco retailers are prohibited from selling tobacco products. Existing tobacco retailing businesses operating within 500 feet of another tobacco retailer will become nonconforming uses. A nonconforming use will be allowed to continue operating under the ordinance.
c) No NEW "Significant Tobacco Retailers", including vape shops, hookah bars or smoke shops are allowed. A "Significant Tobacco Retailer" is defined as having more than 20% of retail sales space dedicated to tobacco retailing use.

Ordinance 2017-01 Tobacco Product and Retail Sales Control (effective 1/1/18) states:

a) The definition of "tobacco products" and "smoke" includes all electronic smoking devices and liquids, including all electronic devices that could be used to deliver a dose of nicotine or other substances.
b) The sale of flavored tobacco products, including menthol cigarettes, is prohibited within 1,000 feet of schools, parks, playgrounds, and libraries.
c) The sale of cigars, including little cigars and cigarillos, is prohibited in pack sizes under ten (10). Premium cigars that sell for $5.00 (including taxes and fees) or more are exempt from this provision.
d) No tobacco retailer's license will be issued that authorizes tobacco retailing in a pharmacy.
e) Compliance with state and local storefront signage and drug paraphernalia sales laws is required in order to maintain a Contra Costa Tobacco Retailer License.

f) Tobacco retailers are required to check identification (ID) of customers who appear younger than 27 years of age.
g) The number of retailers that can sell tobacco products is "capped" at current number of licenses issued by the County. (effective 8/17/17)

Condition of License Suspension if a Violation of the Law Occurs:
h) Tobacco retailers who have their license suspended due to violations of the law are required to remove tobacco advertising during license suspension periods.
i) The time period reviewed for prior violations of the license (the "look-back" period) is expanded from 24 months (2 years) to 60 months (5 years) when considering the length of time for a license suspension for retailers found to be in violation of the law.

Retailers found to be in violation of the law can be fined up to $500 for each day that they are in violation, per County Code 14-12.006, "Administrative fines," and may face suspension or revocation of their tobacco retailer license.

III. Implementation

A. Recap of implementation efforts from July 2017 adoption through March 2018 report to the Board of Supervisors. Extensive outreach efforts were made from September to December 2017 to notify and educate tobacco retailers about new tobacco control laws. This included a notification letter sent in September, phone calls to retailers in November, and educational site visits to retailers in December leading up to the January 1, 2018 compliance date. These site visits included review and provision of newly developed flyers with notice of new laws and visual examples of restricted products. Staff responded to 95 requests for technical assistance to tobacco retailers through email, phone calls, and office visits in January 2018 to clarify location of stores, what laws applied based on location, and what products were restricted. Post-compliance visits were made to retailers in February 2018, which found an overall compliance rate of 74% (see table below). Warnings were issued to any retailers found in violation at the time of the visit and staff provided additional education to retailers about measures they could take to remedy the violation (e.g., removing restricted products, explaining what constituted a flavored tobacco product, ensuring no tobacco products were displayed for self-service). A tobacco retailer licensing brochure was developed with information on the new laws, how to apply for a tobacco retailer license, and resources to maintain compliance.

Store Visit Dates	% of stores visited	% of stores visited sold small packs of cigars	% of stores visited (near YSAs) sold flavored tobacco products	% of stores visited compliant with pack & flavor restrictions
Dec 2017	85%	76%	95%	NA – pre compliance
Feb 2018	92%	17%	22%	74%

B. Implementation efforts with tobacco retailers since March 2018 report to the Board of Supervisors. By June 2018, warning letters were mailed to all retailers who had been found in violation of new tobacco control laws during the February post-compliance visits, while retailers who complied with the new laws were mailed letters thanking them for their compliance. Public Health staff worked with the Business License Office to include information about tobacco retail information and resources in the annual mailing to all business owners. As of July 1, 2018, all pharmacies were prohibited from selling any tobacco products, and staff provided technical assistance to those pharmacies to achieve compliance.

The Tobacco Retailer Businesses Zoning law prohibits new tobacco retailers from locating within 1000 feet of schools, parks, playgrounds and libraries, and within 500 feet of another tobacco retailer. While this law is in the Zoning Code, the Public Health staff coordinates all aspects of the license approval process to assure that all tobacco related regulations are complied with prior to annual licensing of tobacco retailers and over the annual licensing period. Public Health and Department of Conservation and Development staff developed a protocol for license approval in August 2017 which remains in place. As needed, Public Health Staff provide technical assistance to Department of Conservation and Development front line staff that interact with tobacco retailers requesting zoning verification.

C. Next Steps for Increased Compliance. Public Health staff has been collaborating with the Sheriff's Office to finalize a MOU to conduct tobacco retail compliance inspections, including youth decoy and shoulder tap operations for enforcement of sales to minors, which are planned for later this year. During those discussions, a new funding source was discovered to cover the costs of enforcement that would otherwise be paid out of County general funds. The California Department of Justice released three rounds of Requests for Proposals for law enforcement related agencies and schools to apply for funding to combat youth use of and access to tobacco products. Staff provided technical assistance to the Sheriff's Office to apply for the first round of funding in March to support youth decoy and shoulder tap operations to enforce tobacco sales to minors law. The Sheriff's Office was awarded these funds and is working with the funder to clarify the scope of work.

The second round of funding was offered in May, and the Public Health staff recently applied for the third round of funding offered in October. This would fund local tobacco enforcement activities from November 2018 through June 2021 complementary to those enforcement activities charged to the Sheriff's Office. As a designated enforcement agency for tobacco retailer licensing laws, Public Health staff proposed to conduct tobacco retail compliance inspections, provide retailer educations sessions, and conduct outreach and education to K-12 schools, colleges, and youth-serving organizations to combat youth and young adult tobacco use including vaping, among other educational and outreach activities. Public Health staff have been in contact with the Sheriff's Office to coordinate enforcement activities proposed for funding through the California Department of Justice. Once recipients selected for funding are announced from the third round of proposals, Public Health Staff will work with the Sheriff's Office to finalize a MOU outlining activities needed to local tobacco control laws that may fall outside activities funded through the California Department of Justice. Tobacco retailer compliance inspections are a priority and will be conducted at least twice annually moving forward.

Sherriff's Office staff will participate in training on new protocols for enforcement of sales to minors, including protocols for using older young adult decoys now that the minimum sales age

of tobacco has been increased from 18 to 21, and use of new and emerging tobacco products. This training is scheduled for December 2018 in San Pablo and provided by the California Food and Drug Branch, which is charged with the Stop Tobacco Access to Kids Enforcement (STAKE) Act.

D. **Technical Assistance to Contra Costa Cities.** Members of the Board of Supervisors directed staff to communicate with Contra Costa cities on these new tobacco control policies. Public Health staff conducted a presentation about local tobacco retail implementation efforts at the June 8, 2018 Contra Costa Mayors Conference and offered technical assistance to Contra Costa cities that were interested in considering similar laws. Staff continue to respond to requests from Contra Costa cities and have provided technical assistance to the cities of Richmond, San Pablo, Concord, Oakley, Danville, and San Ramon which have considered similar tobacco retail control policies for their jurisdictions based on the model provided by the County.

E. **Technical Assistance to Statewide Tobacco Control.** In June 2018, Public Health staff produced an evaluation report of local tobacco retailer license implementation efforts, which provided a thorough account of materials and methods used to achieve compliance with the newly adopted provisions. Since few jurisdictions across the state had adopted such comprehensive provisions with successful implementation, this report has since been used as a model for tobacco retailer licensing implementation for jurisdictions across the State.

Public Health staff was selected by the California Department of Public Health's Tobacco Control Program to participate in a panel presentation on successful implementation of Contra Costa's local tobacco retailer licensing laws at the statewide tobacco projects meeting in November. The California Youth Advocacy Network has also asked staff to present on Contra Costa's successful efforts to engage youth in local tobacco policy as a model for other jurisdictions at the same statewide tobacco projects meeting in November.

IV. Recommendations

Staff recommends that the Family and Human Services Committee accept the report and direct staff to continue to provide updates on implementation of the ordinance as part of staff's annual report on the County's Tobacco Retail Licensing Ordinance.

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Contra Costa County Assisted Outpatient Treatment (AOT) Evaluation

Cumulative Evaluation Report

Prepared by:

Resource Development Associates

October 26, 2018

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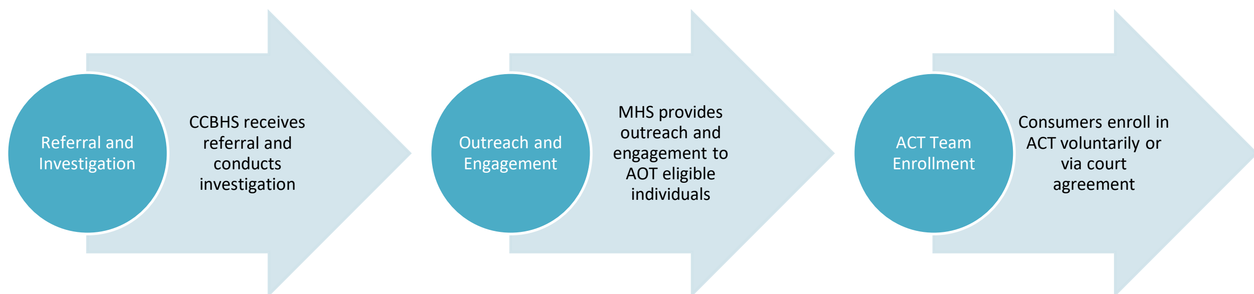
Executive Summary

In California, Assembly Bill (AB) 1421 (also known as "Laura's Law") authorizes 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/or 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. In February 2015, Contra Costa County began a 36-month AOT pilot project, including civil court intervention, to determine if it would effectively identify, engage, and treat individuals who were unable to engage in existing adult mental health services and interrupt the cycle of crisis and hospitalization, incarceration, and/or homelessness. The County also elected to implement Assertive Community Treatment (ACT), which is an evidence-based approach that provides the highest level of outpatient services available in the community for those who need it most. Contra Costa's AOT program represents a collaborative partnership between Contra Costa Behavioral Health Services (CCBHS), the Superior Court, County Counsel, the Public Defender, and Mental Health Systems (MHS).

The Contra Costa County AOT program includes a Care Team comprised of CCBHS Forensic Mental Health (FMH) and the MHS ACTiOn team (ACT providers). The two main components of the AOT program are Pre-Enrollment (Referral and Investigation; Outreach and Engagement) and AOT Enrollment (ACT outpatient treatment services).



Contra Costa County contracted with Resource Development Associates (RDA) to conduct an evaluation of its AOT pilot program. This report presents findings about the AOT program spanning the period of February 2016 through June 2018. Three key questions guided RDA's evaluation:

1. What are the outcomes for people who participate in ACT and AOT, including the DHCS required outcomes? How faithful are ACT services to the ACT model?
2. What are the differences in demographics, service patterns, and outcomes between those who agree to participate in ACT services voluntarily and those who participate with an AOT court order or voluntary settlement agreement?
3. What are the differences in demographics, service utilization, and outcomes between those who engage in existing Full Service Partnership (FSP) services and those who receive ACT services?

Key Process Findings

Implementation Challenges and Improvements: In the initial stages of AOT implementation, County agencies collaborated on the new processes and procedures required to support the referral and investigation process as well as the court component. As with any new program in its formative stages, there were unanticipated challenges along the way that the County and stakeholders worked together to address, including how to:

- Ensure that qualified requestors had the knowledge and resources to make appropriate referrals to the program for individuals most in need;
- Reduce the length of time from referral to enrollment, particularly for those individuals who were continuing to experience crisis, hospitalization, incarceration and/or homelessness during the investigation and outreach process;
- Determine the most efficient and effective ways for FMH and MHS to work together with referred individuals, engage them in care, and identify the need for a civil court petition where indicated; and
- Discern the appropriate use of the petition and benefit of the civil court component to encourage participation in ACT services.

While the County and partners worked diligently to identify and resolve these issues as they arose, the net impact early on in the process was that not all qualified requestors were equipped to do so, enrollment in the program took longer than expected for eligible individuals, and there was hesitation to implement the court component. This resulted in a lower census than originally estimated despite a continued perception of need for these high-end services. Along the way, the County and its partners sought to proactively identify and address issues as well as seek input from stakeholders, elected officials, and the evaluation team as to how they might continuously improve the program. Their investments in ongoing continuous quality improvement ultimately increased the diversity of qualified requestors, shortened the length of time from referral to enrollment, more swiftly implemented the court component for those who require that level of support, and increased the number of consumers who are enrolled in and benefitting from the program.

ACT Fidelity: ACT has one of the strongest evidence-bases of any mental health intervention for reducing crisis and hospitalization, incarceration, and homelessness for those with the most serious mental illness when performed to fidelity. While the ACT team did experience some challenges early on with recruitment and hiring and understanding that the use of AOT and the civil court component was in alignment with the ACT model, as well as the staff turnover experienced in early-2018, they continue to score in the high-fidelity range across all three annual fidelity assessments.

Key Outcomes Findings

Over the course of the nearly 2.5 years of implementation, the AOT program received 475 duplicated referrals, of which about one-third resulted in a subsequent referral to MHS for outreach and engagement into the AOT program. Seventy consumers enrolled in AOT during this evaluation period. These AOT consumers were primarily male in gender, White in race/ethnicity, and over age 26. MHS' ACT team provided a high amount of services (average of four hours of face-to-face contacts a week) on a very frequent basis (average of four contacts per week) to its consumers. Moreover, two-thirds of consumers

were adherent to their ACT treatment services, demonstrating the AOT population was really engaged in their treatment.

In order to assess how this AOT program impacted its consumers, RDA's evaluation examined how key outcomes of interest changed for the AOT population from prior to their AOT participation to during/after program enrollment. Key outcomes findings include:

- ❖ Consumers experienced significant decreases in both the amount and frequencies of crisis episodes and psychiatric hospitalizations during ACT enrollment.
- ❖ Significantly fewer consumers were arrested and booked in jail during ACT enrollment.
- ❖ The majority of consumers either obtained or maintained housing during while enrolled in ACT.
- ❖ Over one-third of consumers continued to experience crisis episodes and/or psychiatric hospitalizations after being discharged from ACT, signaling these consumers may have been prematurely discharged.
- ❖ The AOT program produces an estimated $371,069 of hard cost savings per year, including cost avoidance from reduced outpatient and residential mental health service as well as jail costs.

Given that AOT consumers join the program in one of two ways (voluntarily agreeing to services or being given a court order to participate), this evaluation examined potential differences in outcomes between these two types of AOT consumers and discovered the following:

- ❖ A larger proportion of court-involved consumers had lower service participation compared to voluntarily enrolled consumers.
- ❖ Consumers who enrolled voluntarily saw a substantial decrease in crisis episodes, inpatient hospitalizations, and justice involvement during ACT.
- ❖ A larger proportion of voluntarily enrolled consumers were stably housed compared to court-ordered consumers.

In Contra Costa County, there was an existing network of FSPs providing outpatient mental health services to the seriously mentally ill. RDA's evaluation discovered the following key findings comparing the outcomes of FSP versus ACT consumers in the County:

- ❖ The FSP and ACT populations were similar across age and gender, but differed in that the ACT population had a greater proportion of White and smaller proportion of Black and Latino consumers. ACT consumers were also more likely to be diagnosed with a disorder that included psychosis.
- ❖ Compared to FSP consumers, ACT consumers engaged in services more often and for longer durations, as well as received more direct services.
- ❖ Both the ACT and FSP consumer populations experienced decreases in numbers and frequencies of crisis episodes and psychiatric hospitalizations.

It is clear that individuals with serious mental illness who participate in AOT and ACT experience notable benefits, specifically in reducing experiences of crisis and hospitalization, incarceration, and homelessness. While this program took longer than originally anticipated to get started and there were challenges to address along the way, the County and its partners worked diligently over the pilot period to strengthen the program and ensure that those individuals most in need had access to services that were likely to help them.

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/or 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).

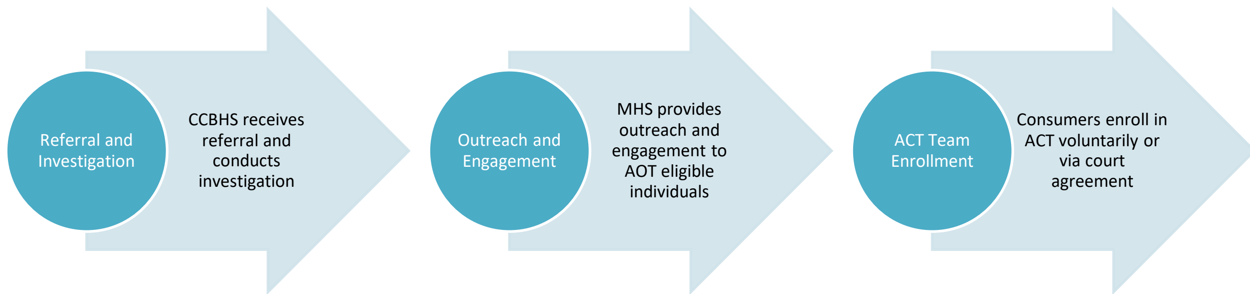
Contra Costa recognized that while they had Full Service Partnership (FSP) programs funded by the Mental Health Services Act (MHSA), there remained a group of individuals who were cycling in and out of crisis and hospitals, jails, and homelessness. In order to address this issue, the Contra Costa County Board of Supervisors adopted a resolution to authorize the implementation of AOT for a 36-month pilot project on February 3, 2015 and pilot AOT, including civil court intervention, to determine if it would effectively identify, engage, and treat individuals who were unable and/or unwilling to engage in existing adult mental health services and interrupt the cycle of crisis and hospitalization, incarceration, and/or homelessness. The County also elected to implement Assertive Community Treatment (ACT), which is an evidence-based approach that provides the highest level of outpatient services available in the community for those who need it most. Contra Costa's AOT program represents a collaborative partnership between Contra Costa Behavioral Health Services (CCBHS), the Superior Court, County Counsel, the Public Defender, and Mental Health Systems (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.

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 the MHS ACTiOn team (ACT providers). 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.

[1] Welfare and Institutions Code, Section 5346

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 from FMH 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).

If the individual initially appears to meet eligibility criteria, a CCBHS investigator from the FMH staff facilitates a face-to-face meeting with the individual and/or family to gather information, attempts to engage the individual, and develops an initial care plan. If the referred individual does not meet AOT eligibility criteria, FMH staff attempts to connect them to other mental health services to meet their needs or reconnect them to services that had previously been effective. If the individual continues to appear to meet AOT eligibility criteria, FMH investigators share their information with the MHS team. MHS then conducts a period of outreach and engagement activities with the individual to encourage their participation in ACT. If at any time the individual 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 individual does not accept voluntary services and continues to meet AOT 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 individual has the option to enter into a voluntary settlement agreement with the court to participate in AOT. If the individual still 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 individual continues to meet AOT criteria, they may authorize an additional six-month period of mandated participation. At every stage of this process,

[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.

CCBHS' FMH and MHS staff continue to offer the individual opportunities to engage voluntarily in services and may recommend a 72-hour hold if they meet the existing criteria. It is important to note that both the voluntary settlement agreement and AOT court order are both agreements between the individual and the court and involve judicial supervision. It is also important to acknowledge that those individuals who agree to participate in ACT on a voluntary basis and without a petition filing or agreement with the court are not formally supervised by the court.

AOT and ACT in Contra Costa County

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 consumer fails to participate in services; and
- After the consumer participates in treatment, if they request discharge prematurely.

When the County first chose to implement AOT, it also elected to implement a new level of outpatient mental health services through an ACT team, complementing the County's established FSP programs that were already serving individuals with serious mental illness. It is not a requirement of AOT programs to offer ACT services to their consumers. Mental Health Services (MHS) is the contracted agency hired by CCBHS to implement the ACT team for County residents referred to AOT.

It is also important to note that the use of a civil court order process is in alignment with the ACT model when the individual requires that level of support to participate. Fidelity to the ACT model includes the expectation that ACT programs apply assertive engagement mechanisms, including all available 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.

External Evaluation

Contra Costa County retained Resource Development Associates (RDA) to conduct an independent evaluation of its AOT program implementation and outcomes. The purposes of this evaluation are to: 1) satisfy California Department of Healthcare Services (DHCS) reporting requirements; 2) provide information to the Contra Costa County 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 four distinct evaluation reports, including two reports mandated by DHCS, and two additional reports written specifically for CCBHS to better understand the implementation of its AOT program. These reports have 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 each produced

approximately six months apart and document the implementation and continued progression of the AOT program since it began.

The purpose of this evaluation report is to assist Contra Costa County with identifying the program's accomplishments and opportunities for improvement. To accomplish this, RDA provides a comprehensive evaluation that assesses:

- AOT program outcomes, including the extent to which MHS is implementing ACT to fidelity, and DHCS required outcomes for people who participate in the County's AOT program;
- Differences in demographics, service patterns, and outcomes between those who agree to participate in ACT services without court involvement and those who participate with an AOT court order or voluntary settlement agreement; and,
- Differences in demographics, service utilization, and outcomes between those who engage in existing FSP services and those who receive ACT services.

Report Overview

This report is intended to address three key evaluation questions that will enable CCBHS to understand the outcomes of ACT programming, differences between the court-involved and voluntarily enrolled ACT consumers, and differences between ACT and FSP consumers. To address these questions, this report is organized in the following format:

- **Introduction**: This section summarizes the background of AOT legislation and provides a description of Contra Costa County's AOT program model and the overarching evaluation questions.
- **Methodology**: This section describes the data sources used to address the evaluation questions, the analytic steps taken to answer each question, and the limitations of the analyses.
- **Question 1 | ACT Consumer Findings**: This section provides a detailed discussion of ACT consumers' experiences from referral through enrollment and, when appropriate, discharge. Findings include pre-enrollment investigation and outreach and engagement; consumer profile; service participation; outcomes including crisis episodes, inpatient hospitalizations, housing, social functioning and independent living; and costs and cost savings.
- **Question 2 | ACT and AOT Comparison Findings:** This section looks at the same components as Question 1, but with a comparison of findings based on those ACT consumers who enrolled voluntarily and those AOT consumers who required civil court involvement to participate. Findings for individuals who enrolled in ACT voluntarily are compared to findings for those who enrolled with court involvement; both voluntary settlement agreement and AOT court order are included in the AOT consumer population.
- **Question 3 | ACT and FSP Comparison Findings:** This section also looks at the same components as Question 1, but with a comparison of findings for all ACT consumers and for consumers who enrolled in an FSP during the same time that ACT was implemented in the County.

- **Summary of Findings:** This final section summarizes and integrates findings from each research question to highlight key overarching findings that may be used to inform decision-making and next steps for AOT program implementation in Contra Costa County.

Methodology

Evaluation Approach and Overview

The following evaluation report was guided by a rigorous methodological approach that addresses real world constraints and documents the actions and outcomes resulting from the County's investments in ACT and AOT, with an emphasis on continuous quality improvement throughout implementation. The evaluation will also likely inform decision-making at the end of the 36-month pilot project. This report is a cumulative evaluation of CCBHS's AOT program since its implementation began in February 2016. As such, it reflects on recommendations made in previous reports and discusses findings in light of those recommendations with a recognition for the natural growth and change that occurs in the delivery of a new program within the behavioral health system.

This evaluation report spans from the AOT program start date, February 1, 2016 through June 30, 2018. Figure 2 presents the overarching research questions that guide this report.

Figure 2. Evaluation Research Questions

Question 1	Question 2	Question 3
• What are the outcomes for people who participate in ACT and AOT, including the DHCS required outcomes? How faithful are ACT services to the ACT model?	• What are the differences in demographics, service patterns, and outcomes between those who agree to participate in ACT services voluntarily and those who participate with an AOT court order or voluntary settlement agreement?	• What are the differences in demographics, service utilization, and outcomes between those who engage in existing FSP services and those who receive ACT services?

In order to answer these questions, RDA employed a mixed-methods evaluation approach to assess: 1) the implementation of the County's AOT program, 2) the extent to which individuals receiving AOT services have experienced decreases in homelessness, crisis, hospitalization, and incarceration, and 3) improvements in AOT consumers' psychosocial outcomes, such as social functioning and independent living skills.

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

Target Populations for Evaluation

This report examines three distinct consumer populations, all of whom have a serious mental illness and a history of crisis and hospitalization, incarceration, and/or homelessness.

1. **FSP consumers** are individuals who enrolled in and received services from an FSP program. FSP consumers are generally those who are experiencing crisis and hospitalization, incarceration, and/or homelessness and are willing and able to engage in voluntary services without additional support. Generally, these individuals are able to follow through with services enough so as not to require a separate referral or outreach and engagement from a third party or civil court involvement.
2. **ACT consumers** are individuals who enrolled in and received services from the MHS ACTiOn team voluntarily (i.e., they did not require civil court involvement to compel participation). ACT consumers are generally those experiencing crisis and hospitalization, incarceration, and/or homelessness and are willing and able to engage in voluntary services with strong encouragement from a third party. With this population, a qualified requestor has referred them to the program and FMH and/or MHS has proactively provided outreach and engagement to encourage participation. Unlike FSP, these consumers require additional support to connect to mental health services and have not been successful in accomplishing this independently. However, with this assertive outreach and engagement, they are able to participate in mental health services without court involvement.
3. **AOT consumers** are individuals who required civil court involvement to compel their participation in mental health services. This group of consumers has been referred by a third party, and despite FMH and/or MHS' proactive outreach and engagement, have been unable to consent to needed mental health services voluntarily. Unlike the FSP and ACT consumer populations, these consumers require civil court compulsion to participate in outpatient mental health services.

Data Sources

The evaluation includes data from CCBHS, MHS, and the Contra Costa County Sheriff's Office. Throughout the data collection and analysis process, RDA collaborated with CCBHS and MHS staff to vet analytic decisions and findings. Table 1 below outlines the data sources and elements used for this report.

Table 1. 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	• Investigation attempts
	Contra Costa County PSP Billing System	• Behavioral health service episodes and encounters,

County Department/Agency	Data Source	Data Element
		including hospitalizations and crisis episodes • Consumer diagnoses and demographics
	CCBHS Financial Data	• Costs associated with implementing the AOT program, including ACT
	Point-in-Time KET Forms (Key Event Tracking) collected from all ACT and FSP clients during July 1 - August 15, 2018	• Homelessness and employment measures
Mental Health Systems	MHS Outreach and Engagement Log	• Outreach and engagement encounters
	FSP Forms (Partner Assessment Form and KET)	• Residential status, including homelessness • Employment • Education • Financial support
	MHS Outcomes Spreadsheet (Self-Sufficiency Matrix, Brief Psychiatric Rating Scale – Expanded, MacArthur Tool)	• Social functioning • Independent living • Recovery • Violence and victimization
	ACT Fidelity Assessment (conducted by RDA in July 2018)	• Key informant interviews with ACT managers and providers • Focus groups with ACT consumers and family members
Contra Costa County Sheriff's Office	Sheriff's Office Jail Management System	• Booking and release dates • Booking offense

RDA matched consumers across the disparate data sources described above and used descriptive statistics (e.g., frequencies, mean, and median) for all analyses, as well as inferential analyses to evaluate the extent to which changes in consumer outcomes were likely a result of program participation versus chance, when appropriate.

The following section provides detail regarding the analytic approach for each evaluation question.

Analytic Approach

Evaluation Question 1: What are the outcomes for consumers who participate in ACT and AOT, including the DHCS required outcomes? How faithful are ACT services to the ACT model?

Pre-Enrollment: To understand how referral, investigation, and outreach and engagement processes are going, RDA employed descriptive statistics to highlight: the number of referrals to AOT; types of referral

sources; types, frequencies, and location of outreach and engagement activities; time period between referral and enrollment; and dispositions of each referral. RDA also examined the extent to which individuals who were referred to ACT services but did not enroll were connected to appropriate mental health services, and/or experienced crisis and hospitalization.

Consumer Profile and Service Outcomes: In order to describe Contra Costa County's ACT population, RDA calculated basic frequencies and percentages to examine the demographic attributes (e.g., age, race, and gender); clinical profiles (e.g., primary diagnosis, presence of co-occurring substance abuse disorder); and education, employment, and sources of financial support of all individuals enrolled in ACT since AOT was implemented in Contra Costa County. In addition, RDA examined the types, lengths, frequencies, and durations of services and programs that ACT program participants utilized, ultimately assessing the extent to which they maintained adherence to their treatment plans once enrolled in ACT (treatment adherence is defined as receiving at least one hour of face-to-face engagement with the ACT team at least two times a week).

ACT Consumer Outcomes: In order to assess changes in consumer outcomes such as homelessness, crisis, and hospitalization, RDA employed a pre/post-test design to measure consumer experiences prior to and during ACT enrollment. To measure changes in housing status, RDA assessed the proportion of ACT consumers who self-reported experiencing homelessness in the year prior to and during ACT enrollment. RDA also analyzed the proportion of ACT consumers who experienced crisis episodes, psychiatric hospitalizations, and criminal justice system involvement in the three years prior to and during ACT enrollment, as well as the rate (per 180 days) at which consumers experienced these outcomes, and the average length of each episode. RDA conducted statistical hypothesis tests to assess whether reductions in the proportion of ACT consumers who experienced crisis and hospitalization prior to and during ACT were likely the result of ACT participation, rather than chance.

Clinicians administer the Self-sufficiency Matrix, Brief Psychiatric Rating Scale-Expanded (BPRS-E), and the MacArthur Tool to assess outcomes such as social functioning and independent living; symptomology; and violence and victimization respectively. RDA measured changes in these assessment scores among all ACT consumers who received an assessment at intake (or as close to intake as possible), and at least one follow-up assessment six months after their initial assessment. In addition, the County required MHS (and all FSPs) to administer summary Key Event Tracking (KET) forms in July and August of 2018 to assess the extent to which consumers participated in significant meaningful activities, measured as changes in self-reported employment-related activities including job training, volunteering, part-time, and full-time work.

ACT Fidelity: To determine whether MHS' ACT services were provided to fidelity, RDA conducted a separate ACT fidelity analysis. The fidelity assessment process measures the extent to which MHS' ACT treatment services align with the ACT model and to identify opportunities to strengthen ACT services. For the assessment, RDA applied the ACT Fidelity Scale developed at Dartmouth University[3] and incorporated

[3] ACT Fidelity Scale retrieved on December 6, 2017 from: https://www.centerforebp.case.edu/resources/tools/act-dacts

it into a SAMHSA toolkit.[4] This established assessment includes a set of data collection activities and a scoring process in order to determine a fidelity rating as well as qualifications of assessors. MHS' ACT program was rated across 28 items within the 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 five-point Likert scale with clearly defined descriptions for each rating. In this report, RDA presents MHS' ACT fidelity scores for the assessments conducted annually in both 2017 and 2018.

Cost: To determine the financial impacts of implementing the ACT program, RDA analyzed data from three sources: 1) AOT operation costs; 2) billing data for treatment services provided by MHS, County mental health crisis units, and County inpatient psychiatric hospitalizations; and 3) Sheriff's Office data on jail bed days spent by ACT consumers. The treatment services billing data includes the specific dollar amounts that were billed for each service; the expected Medi-Cal reimbursement was then subtracted from the total charges to determine the total cost to the County. The Sheriff's Office data, when paired with the estimated cost for an average jail bed day in Contra Costa County, represents the costs incurred by the criminal justice system for incarceration.

Evaluation Question 2: What are the differences in demographics, service patterns, psychosocial outcomes, and cost between those who agree to participate in ACT services without court involvement and those who participate with an AOT court order or voluntary settlement agreement?

RDA replicated the analyses described above for all individuals who enrolled in ACT services voluntarily versus those who enrolled in ACT with court involvement in order to assess differences in consumer profiles, service utilization, and outcomes associated with each population. Because only 16 individuals enrolled in ACT with court involvement, RDA aggregated the data to maintain confidentiality when appropriate.

Evaluation Question 3: What are the differences in demographics, service utilization, psychosocial outcomes, and cost between those who engage in existing FSP services and those who receive ACT services?

In order to evaluate differences in demographics, service utilization, and outcomes between the County's FSP and ACT populations, RDA identified all individuals with beginning FSP services on or after February 1, 2016 (the AOT program start date) and replicated the analyses described in the analytic approach for Evaluation Question 1.

[4] 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.

RDA conducted statistical hypothesis tests (e.g., chi-squared tests, etc.) to measure the likelihood that observed differences in consumer demographics and diagnoses were a result of chance, or systematic differences between ACT and FSP consumer characteristics. RDA also conducted chi-squared tests to assess the likelihood that differences in the proportion of FSP and ACT consumers who experienced negative outcomes (e.g. crisis and hospitalization) in the three years prior to and during program enrollment were a result of chance versus real differences between the two groups' experiences. This allowed RDA to evaluate whether these populations had systematically different experiences with these outcomes prior to enrolling in FSP or ACT, and whether these differences remained for consumers during enrollment. RDA also conducted statistical hypothesis tests (i.e., McNemar's test) to assess the likelihood that reductions in the proportion of FSP and ACT consumers who experienced crisis and hospitalization prior to and during program enrollment were likely the result of program participation versus chance.

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 16 consumers participated in the AOT treatment with a court order or voluntary settlement agreement. Because relatively few individuals have enrolled in ACT with court involvement, the proportion of individuals who experienced crisis, hospitalization, and criminal justice involvement, as well as the average rates of occurrence, shift dramatically based on their experiences. As a result, RDA aggregated some consumer characteristics and outcomes to maintain consumer confidentiality.

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 and FSP consumers had greater opportunities to experience negative outcomes prior to program enrollment. To account for these differences in the pre- and post-time periods, RDA standardized outcome measures to rates per 180 days. Nevertheless, because consumers have spent much less time enrolled than in the pre-enrollment period, there was less opportunity for them to experience outcomes such as crisis or hospitalization during the enrollment 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 outcomes may be overestimated.

Lastly, this evaluation only has access to the services paid for by Contra Costa County, which includes the MHS ACTiOn program, CCBHS, the AOT Court, County Counsel, and the Public Defender. The consumers served by this AOT program also receive services from entities not directly paid for by the County. In order to understand the totality of all costs incurred and saved by the consumers participating in AOT, it would be necessary to analyze data from the myriad of entities interfacing with this population. It is a limitation of this evaluation in that it is not possible to obtain this breadth of data.

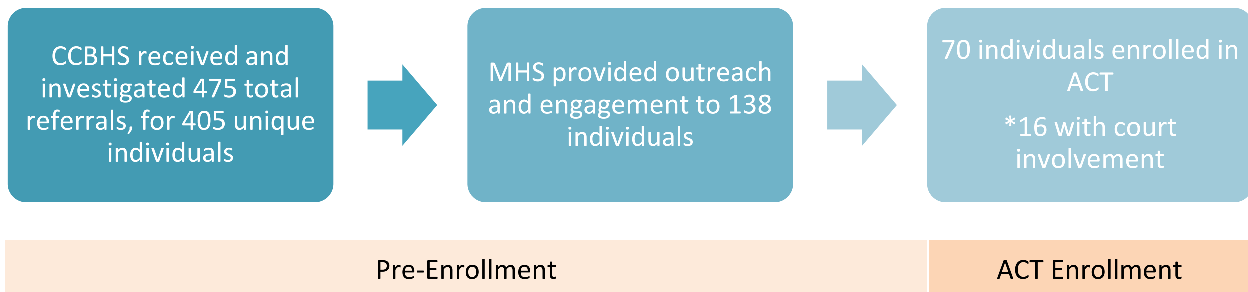
Despite these limitations, this evaluation will help Contra Costa County identify the successes and challenges of its AOT implementation, as well as highlight the outcomes of consumers who participated

in the County's AOT treatment program throughout its implementation. The evaluation findings provide 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.

Question 1 | ACT Consumer Findings

This evaluation section reports findings for all individuals who were referred to AOT since the program began in February 2016. During this time, CCBHS received 475 total referrals for 405 unique individuals. Of the 405 individuals referred throughout implementation, 34% (n = 138) were referred to MHS for outreach and engagement, and 70 eventually enrolled in ACT.

Figure 3. Consumers Referred to AOT since February 2016



As previously documented, CCBHS's AOT program implementation evolved over time as processes were streamlined and partnerships were built. Specifically, the AOT program model changed within the first few months of implementation. As originally designed, the agencies who comprise the Care Team would work concurrently; however, the program model was adjusted so that CCBHS forensic mental health (FMH) clinicians conduct the referral investigation to determine eligibility first, and then they refer eligible individuals to MHS for outreach and engagement. Because the AOT program required multiple new elements to come together at once, it was natural for such programmatic modifications to occur in response to unexpected challenges. The model was also refined throughout implementation in order to 1) ensure that all qualified requestors have the knowledge and ability to refer eligible individuals, 2) decrease the length of time from referral to enrollment, and 3) strengthen the identification of those eligible individuals who may require a court petition to participate in services.

The following discussion of findings for all ACT consumers is divided into two sections: "Pre-Enrollment" and "ACT Enrollment." Throughout each section, findings are reported for three different types of groups:

- **Referrals**: These findings include information reported on (duplicated) individuals who were referred to either the AOT program, or from FMH clinicians to the MSH ACTiOn team more than once. Findings are reported at this level to illustrate the scope of the AOT program and how many total referrals the county received and connected to appropriate behavioral health services. In several instances, an individual was referred to the overall AOT program or to the MHS ACT program more than once.
- **Enrollments**: These findings include information reported on (duplicated) individuals who were enrolled in ACT services more than once. Findings are reported at this level to illustrate both the total number of individuals served by MHS, as well as how many were enrolled more than once.

- **Consumers**: These findings report only on the unique individuals enrolled in ACT. Findings are reported at this level to illustrate the specific outcomes of each consumer enrolled in ACT.

The Care Team provides investigation, outreach, and engagement services for all AOT referrals in order to connect eligible individuals to the ACT program. The Care Team also works to connect those who are not eligible for ACT to other appropriate behavioral health treatment services. The following section explores the outcomes of this process in the "Pre-Enrollment" section, including a discussion of the experiences of individuals who were referred to MHS ACTiOn team but not enrolled. The "AOT Enrollment" section reports on outcomes for individuals who met AOT eligibility requirements and enrolled in ACT.

Pre-Enrollment

CCBHS received referrals from a diversity of qualified requestors, including family members, mental health providers, and law enforcement officials.

Table 2 demonstrates that a qualified requestor made almost all AOT referrals. Family members made over half of referrals, while the individual's mental health provider made 20% of referrals. Law enforcement officials made 13% of referrals. It is important to acknowledge that CCBHS made concerted efforts throughout the program to ensure that qualified requestors were aware of the program and had the knowledge and resources to make appropriate referrals. These efforts included: 1) ongoing training and educational presentations to family members, law enforcement, and mental health provider groups; and 2) specific actions, such as linking law enforcement officers coming into contact with potentially eligible individuals with the CORE team (a County-provided homeless outreach team) so that they could work together to successfully refer those eligible individuals to the program.

Table 2. Summary of Qualified Requestors

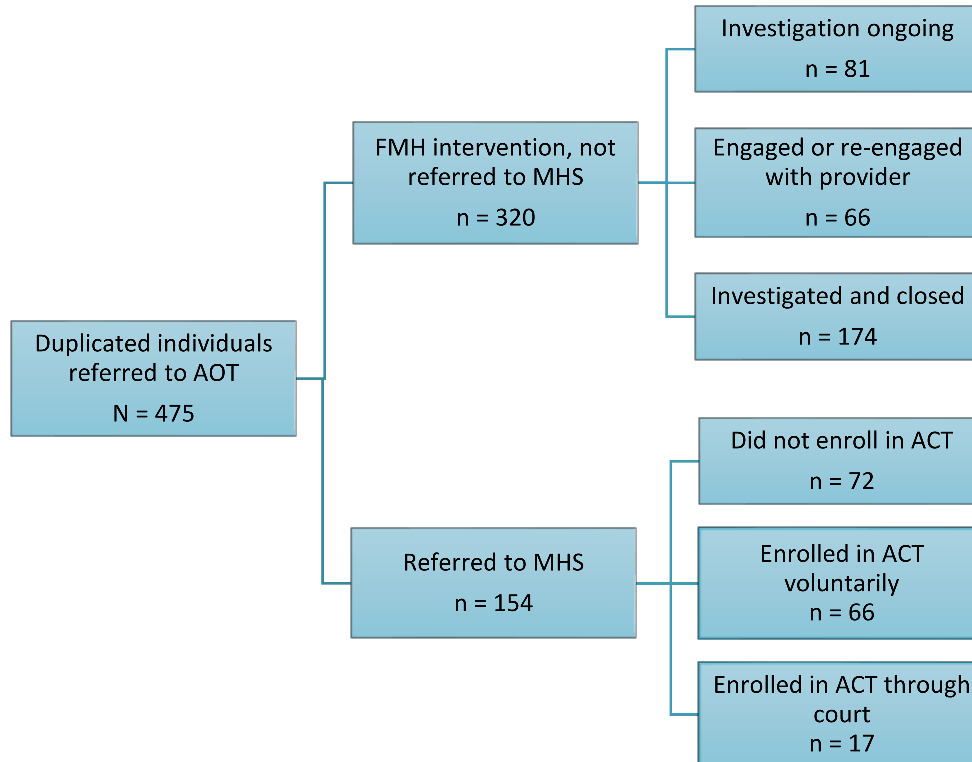
Requestor	Percent of Total Referrals (N = 475)
Parent, spouse, adult sibling, or adult child	60% (n = 286)
Treating or supervising mental health provider	20% (n = 95)
Probation, parole, or peace officer	13% (n = 63)
Not a qualified requestor or "other"	4% (n = 20)
Director of hospital where individual is hospitalized	<3%
Adult who lives with individual	<3%

Care Team

Contra Costa County's Care Team consists of CCBHS' FMH and MHS ACTiOn 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. Figure 4 summarizes the outcome of each referral CCBHS received since February 2016. The summary includes duplicated counts to capture the volume of referrals. The following sections discuss the CCBHS FMH investigations

and MHS outreach and engagement activities. Where appropriate, unique counts of individuals are reported as well.

Figure 4. Outcomes for Every Referral to AOT Referred Consumers



Investigation

After CCBHS receives an AOT referral, the FMH team conducts an investigation to determine if the referred 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.

Nearly every referred individual who was eligible for AOT and/or was able to be located was connected to mental health services.

Since February 2016, FMH received and investigated a total of 475 referrals. Four hundred and five of those referrals were unique individuals (70 individuals had been referred more than once). As Table 3 illustrates, approximately one-third of all referrals (32%, n = 154) resulted in a subsequent referral to MHS for outreach and engagement, while just over another third (37%, n = 174) were investigated and closed. The FMH team connected 14% (n = 66) of referred individuals with another behavioral health service provider, such as an FSP, and another 17% were still under investigation to determine their AOT eligibility as of June 30, 2018.

Table 3. Outcome of CCBHS Investigations

Investigation Outcome	Percent of Referrals (N = 475)
Referred to MHS	32% (n = 154)
Engaged or Re-Engaged with a Provider	14% (n = 66)
Ongoing Investigation	17% (n = 81)
Investigated and Closed	37% (n = 174)

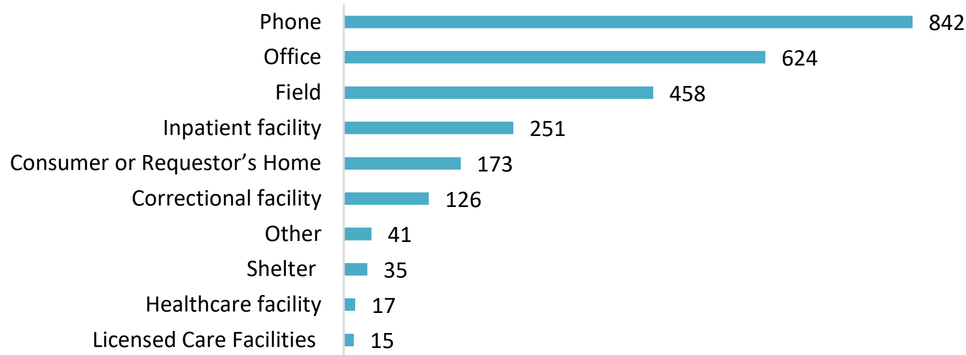
CCBHS FMH attempted to connect the 174 referred individuals who were ineligible for AOT to an appropriate level of mental health treatment, as well as provided resources and education for their family members. Importantly, program implementation modifications (including increased outreach by FMH clinicians to Unit 4C and law enforcement) alongside improved data collection allows for a more specific understanding of what happened to the referred individuals who were considered ineligible for AOT. These individuals were investigated and closed for a number of reasons:

- 56% (n = 98) were closed because the referred individuals did not meet AOT eligibility criteria.
- 16% (n = 27) were closed because the person making the referral was unqualified, could not be reached after the initial request, or rescinded the initial request.
- 12% (n = 21) were closed because the referred individual was unavailable, which includes individuals who were conserved, determined to be incompetent to stand trial, incarcerated, or placed in an Institute for Mental Disease (IMD).
- 9% (n = 16) were closed because the referred individual could not be located after a persistent search.
- 7% (n = 12) were closed because the referred individual either lived or moved out of the county during the investigation.

Contra County's CCBHS FMH investigation team made significant and persistent efforts to locate referred individuals to determine their AOT eligibility and connect them to MHS.

On average, CCBHS FMH's investigation team made five investigation contact attempts for each referral received. The investigation team worked to meet individuals "where they're at," as evidenced by the variety of locations where investigation contacts occurred. Figure 5 shows that 43% of investigation contacts occurred in person at a location other than a county office.

Figure 5. Location of FMH Investigation Contacts



Outreach and Engagement

MHS relies on a diverse multidisciplinary team to conduct outreach and engagement, the MHS ACTiOn team. If the CCBHS FMH team determines that a referred individual is eligible for AOT during the investigation period, the individual is connected with MHS. The MHS ACTiOn team then conducts outreach and engagement activities with those individuals and their families to engage them in ACT services. As per the County's program design, MHS is charged with providing opportunities for the individual to participate on a voluntary basis. If the individual remains unable and/or unwilling to voluntary enroll in ACT after a period of outreach and engagement, 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 has enrolled half of all AOT referred individuals to ACT through their ongoing outreach and engagement efforts.

Since the program began in February 2016, MHS provided outreach and engagement services for 138 consumers and their support networks. Fifty-one percent (n = 70) eventually enrolled in ACT at least once as of June 30, 2018. Notably, eight of those consumers enrolled more than once. Another 12% of referred individuals (n = 17) were still receiving outreach and engagement services as of June 30, 2018 (see Table 4). This trend of approximately half of the individuals whom MHS outreached to ultimately enrolling in ACT stayed about the same during the entire pilot implementation period.

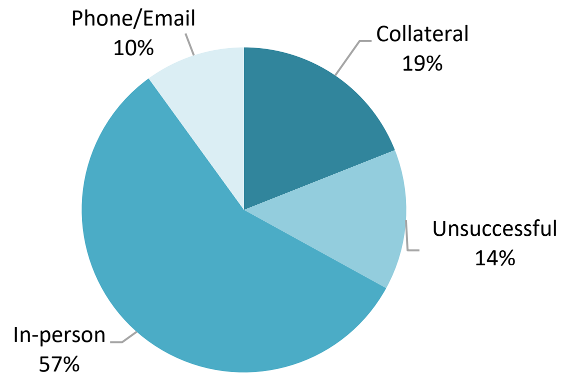
Table 4. MHS Outreach and Engagement Outcomes (N = 138)

Outreach and Engagement Outcome	Percent of Consumers	Number of Consumers
Enrolled in ACT services	51%	70 total *54 voluntarily* *16 with court involvement*
Still receiving outreach and engagement services	12%	17
Not enrolled in ACT	37%	51

The MHS ACTiOn team provided intensive and persistent outreach and engagement to individuals referred to AOT in a variety of settings.

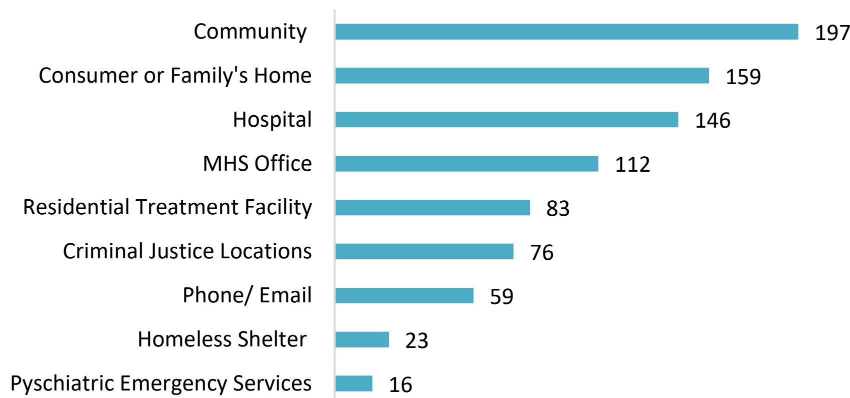
MHS provided outreach and engagement services to individuals as well as their support networks. Approximately 57% of outreach and engagement attempts were successful contacts with individuals, while approximately one in five contact attempts were with the individuals' support networks (collateral), including family members and other providers (see Figure 6).

Figure 6. Type of Outreach and Engagement Contacts



The majority of the MHS ACTiOn team's outreach attempts were either by a peer partner (47%) or the clinical team leader (21%). As with the County's investigation team, MHS was persistent in their efforts to meet consumers "where they're at." As shown in Figure 7, most contacts occurred in the community or the consumer/family home.

Figure 7. Location of MHS Outreach and Engagement Attempts



Many of the individuals who received outreach and engagement services but did not enroll in ACT continued to cycle through crisis, hospital, and jail.

Among the 51 individuals who were referred to MHS and received outreach and engagement but did not enroll in ACT, 73% (n = 37) experienced at least one crisis episode after referral and 13 also had an inpatient hospitalization. Additionally, 41% (n = 21) of those who were referred to MHS but not enrolled in ACT had at least one mental health service while in jail. Approximately 25% (n = 13) engaged in some form of outpatient treatment; however, almost half of those who engaged in outpatient treatment also had an inpatient hospitalization. These findings suggest that a subset of individuals was difficult to engage and may have benefitted from an AOT petition.

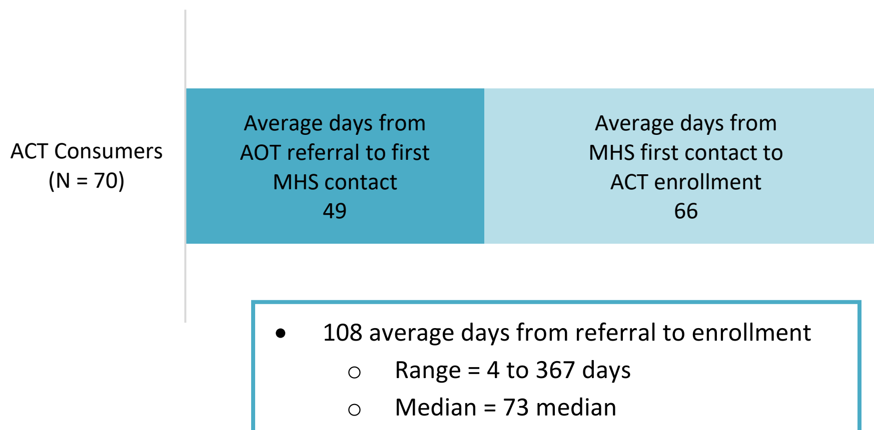
Referral to Enrollment Outcomes

This section explores the time period between consumers' initial AOT referral and their ACT 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 ACT enrollment is 108 days.

Contra Costa County designed an AOT program model that sought to engage and enroll referred individuals in ACT within 120 days of referral. On average, it took the Care Team approximately 108 days to collectively conduct investigation, outreach and engagement, and enroll the referred individuals in ACT. Specifically, it took an average of 49 days from the point of AOT referral to MHS' first contact, and then 66 days from the date of MHS' first contact to enrollment in ACT (see Figure 8). This trend of the average length of time between referral and enrollment for ACT consumers being right under 16 weeks remained consistent during the entire pilot implementation period.

Figure 8. Average Length of Time from AOT Referral to ACT Enrollment[5]



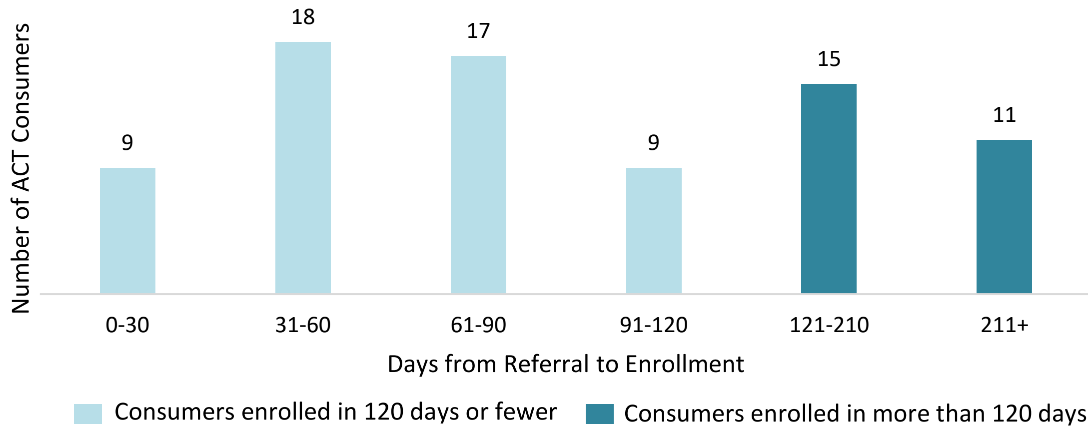
- 108 average days from referral to enrollment
  - Range = 4 to 367 days
  - Median = 73 median

Approximately one out of every three ACT consumers experienced referral to enrollment periods longer than 120 days.

Contra Costa County's AOT program model has an expected maximum period of 120 days 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, 26 consumers (33%) experienced investigation and outreach periods lasting longer than 120 days (see Figure 9). Data suggests that these individuals were difficult to locate, and that the Care Team invested additional time to attempt to locate them.

[5] For consumers with multiple ACT enrollments, each period from referral to enrollment is counted separately.

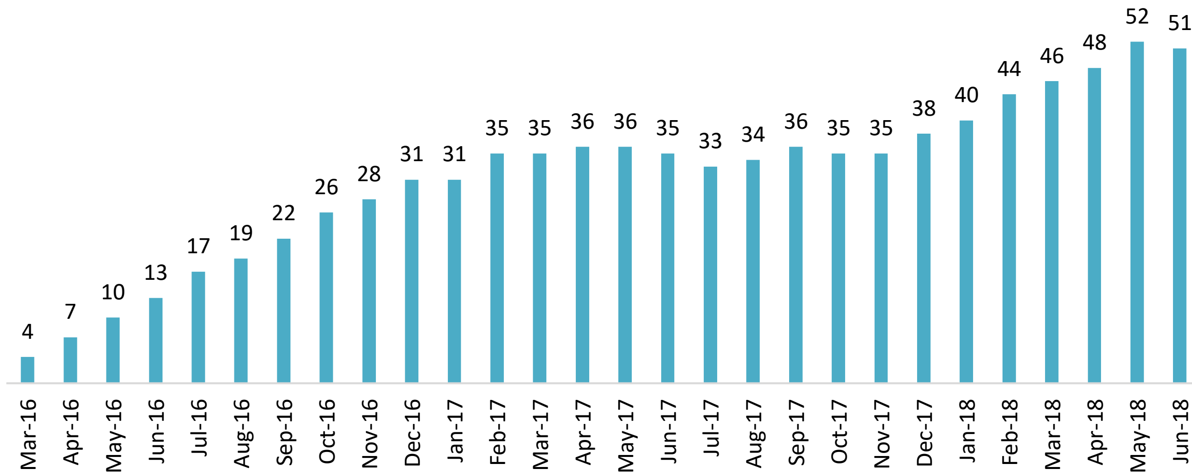
Figure 9. Length of Time from AOT Referral to ACT Enrollment



The ACT program has seen a steady increase in the number of consumers enrolled during its pilot period.

As shown in Figure 10, with few exceptions, the number of consumers enrolled in ACT during any given month has increased since the program began in February 2016. At the conclusion of this evaluation period, MHS was serving 51 enrolled consumers, with 18 individuals either still receiving outreach and engagement services or pending ACT enrollment.

Figure 10. Number of Individuals Enrolled in ACT by Month

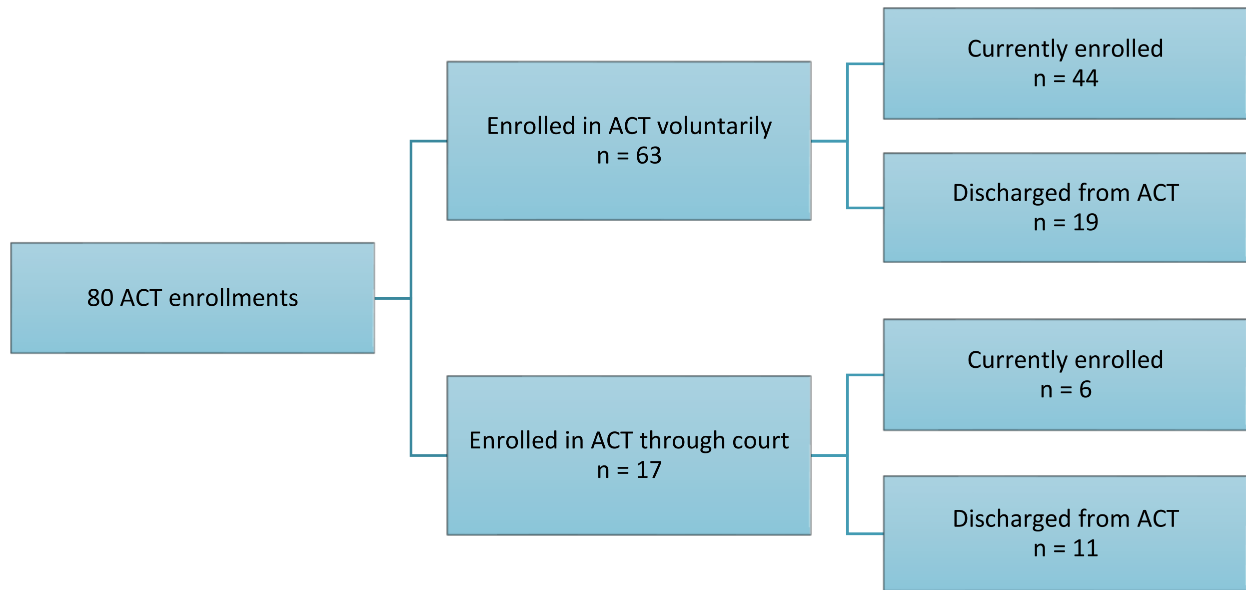


As of October 23, 2018, there were 64 consumers enrolled in treatment services with the MHS ACTiOn team.

AOT Enrollment

As shown in Figure 11 below, MHS had a total of 79 enrollments for 70 individuals since February 2016. Seven individuals were enrolled in ACT more than once, and two of those seven re-enrolled twice. The majority of enrollments (78%, n = 62) were voluntary.

Figure 11. AOT Treatment Program Participants



This section includes the following components:

- A review of the ACT consumer profile, including demographic characteristics, diagnoses and baseline employment, education, and financial status;
- A discussion of consumer outcomes, including the change in their experiences of crisis episodes, inpatient hospitalizations, and homelessness; and
- A discussion of program costs and cost savings associated with reduced numbers of hospitalizations, 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 majority of ACT consumers are male and White and have both primary psychotic disorders and co-occurring substance use issues.

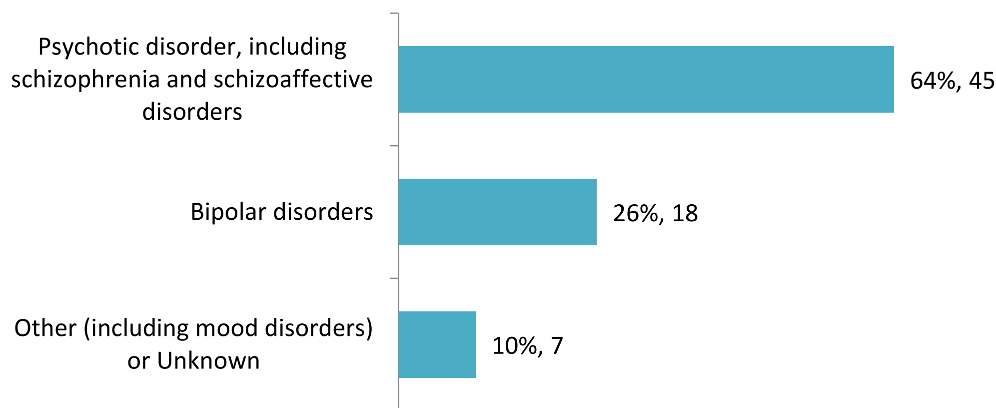
As shown in Table 5, ACT consumers were primarily male (56%, n = 39) and White (56%, n = 39). A subset of 21% (n = 15) were transitional age youth (TAY) between the ages of 18 and 25.

Table 5. ACT Consumer Demographics (N = 70)

Category	ACT Consumers
Gender	
Male	56% (n = 39)
Female	44% (n = 31)
Race and Ethnicity	
Black or African American	19% (n = 13)
Hispanic	16% (n = 11)
White	56% (n = 39)
Other or Unknown	9% (n = 7)
Age at Enrollment	
18 – 25	21% (n = 15)
26+	79% (n = 55)

The majority of ACT consumers (64%, n = 45) have a primary diagnosis of a psychotic disorder (see Figure 12), and 71% (n = 50) had a co-occurring substance use disorder at the time of enrollment.

Figure 12. Primary Diagnosis at Referral (N = 70)



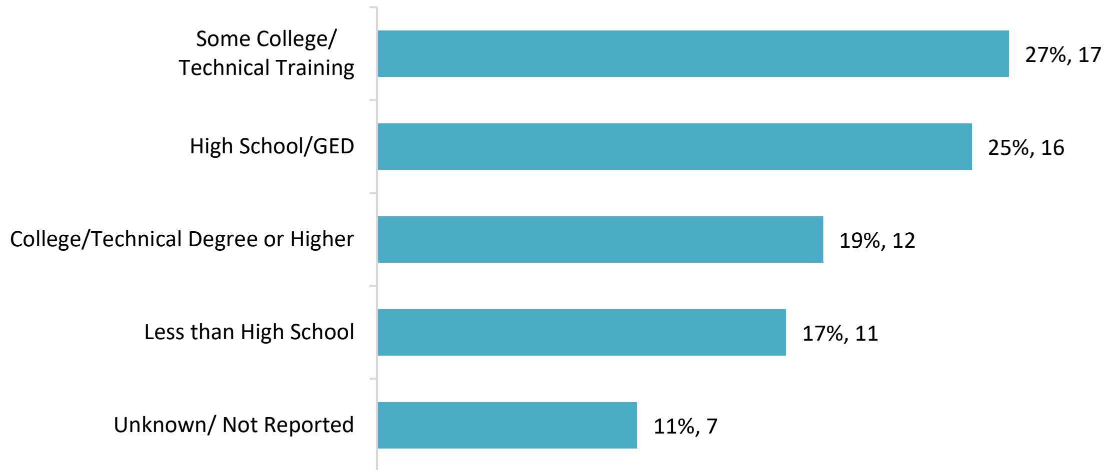
Education, Employment, and Financial Support[6]

Most ACT consumers are unemployed, have minimal post-high school education, and receive financial support from supplemental security income.

At the time of enrollment, no ACT consumers were enrolled in school. Over half of ACT consumers had a GED or higher education level at the time of enrollment (see Figure 13). Slightly more than one-third (38%, n = 24) of consumers specified continuing education as a recovery goal for their time in ACT.

[6] Baseline housing, education, employment, and financial support data were available for 63 of the 70 consumers.

Figure 13. Educational Attainment at Enrollment (N = 63)



Over half of ACT consumers were unemployed during the 12 months prior to their enrollment in ACT (59%, n = 37). Prior employment status was not provided by 33% of consumers (n = 21) (see Figure 14). Obtaining employment was a recovery goal for almost half (46%) of ACT consumers.

Figure 14. Employment 12 months before ACT (N = 63)

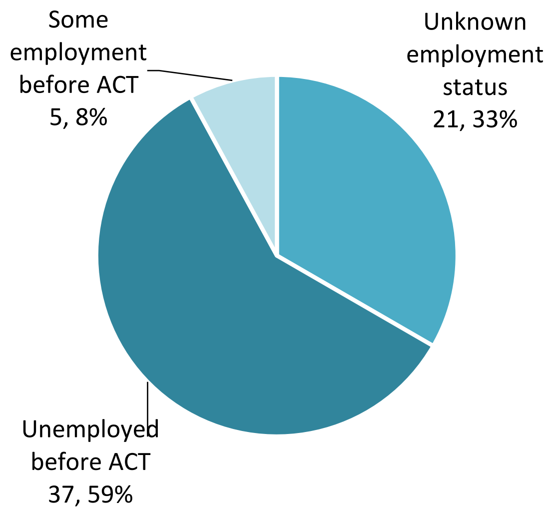


Table 6 illustrates the sources of financial support and income for ACT consumers in the 12 months prior to enrollment, as well as at the time of enrollment. The "Other" category includes a variety of financial support sources: support from family or friends, retirement/Social Security, tribal benefits, wages or savings, food stamps and housing subsidies. The majority of consumers both prior to and at enrollment received financial support from supplemental security income.

Table 6. Sources of Financial Support at and before ACT Enrollment (N = 43)

Financial Support	Support Received in the Year Prior to ACT Enrollment	Support Being Received at ACT Enrollment
Supplemental Security Income	49% (n = 31)	45% (n =29)
Other	36% (n = 23)	30% (n = 19)
No Financial Support or Unknown/Not Reported	14% (n = 9)	24% (n = 15)

Service Participation

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

Fidelity to the ACT Model

To determine whether MHS' ACT services were provided to fidelity, RDA conducted a separate ACT fidelity analysis (see Appendix II). The fidelity assessment process measures the extent to which MHS' ACT treatment services align with the ACT model and to identify opportunities to strengthen ACT services. For the assessment, RDA applied the ACT Fidelity Scale developed at Dartmouth University[7] and incorporated it into a SAMHSA toolkit.[8] This established assessment includes a set of data collection activities and a scoring process in order to determine a fidelity rating as well as qualifications of assessors. MHS' ACT program was rated across 28 items within the 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 five-point Likert scale with clearly defined descriptions for each rating. The following chart provides an overview of the domains, criterion, and the MHS ACTiOn team's 2017 and 2018 program ratings. As shown in Table 7 below, the MHS ACTiOn team received an overall fidelity score of 4.50 indicating a high level of fidelity to the ACT model.

Table 7. MHS ACTiOn Team's ACT Fidelity Assessment Scores (2017 & 2018)

Domain	Criterion	2017 Rating	2018 Rating
Human Resources: Structure and Composition	Small caseload	5	5
	Team approach	4	5
	Program meeting	5	5
	Practicing ACT leader	4	5
	Continuity of staffing	3	4

[7] ACT Fidelity Scale retrieved on December 6, 2017 from: https://www.centerforebp.case.edu/resources/tools/act-dacts
[8] 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.

Domain	Criterion	2017 Rating	2018 Rating
	Staff capacity	4	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	2	5
	Intake rate	5	5
	Full responsibility for treatment services	5	5
	Responsibility for crisis services	5	5
	Responsibility for hospital admissions	5	1
	Responsibility for hospital discharge planning	5	5
	Time-unlimited services	5	5
Nature of Services	In vivo services	3	4
	No drop-out policy	3	5
	Assertive engagement mechanisms	2	5
	Intensity of services	5	4
	Frequency of contact	4	3
	Work with support system	5	5
	Individualized substance abuse treatment	5	3
	Co-occurring disorder treatment groups	5	3
	Co-occurring disorders model	5	5
	Role of consumers on treatment team	5	5
ACT Fidelity Score		**4.42**	**4.50**

There were notable changes in scores for three domains between the 2017 and 2018 ACT fidelity assessment processes conducted with MHS. There was a large decline in the domain regarding the MHS ACTiOn team having some involvement in the decision-making around their consumers' hospital admissions. And, there were large increases in two domains: 1) the MHS ACTiOn team having explicit criteria for whom it admits into ACT services, and 2) the MHS ACTiOn team having and utilizing assertive engagement mechanisms with its consumers.

Intensity and Frequency of ACT Services

As discussed in the methodology section, the following discussion of ACT service participation treats each enrollment individually for intensity and frequency analysis, even if an individual was enrolled more than once, in order to avoid misrepresenting service engagement. Since the program began in February 2016, eight individuals had more than one discrete enrollment. Additionally, any enrollments that were less than one month in duration were removed from the following analysis. Finally, five individuals enrolled in

ACT did not have any available service data and were not included in the analysis. As a result, the following analysis includes 71 total enrollments for 62 unique individuals.

The ACT team is providing a high amount of services on a very frequent basis to its consumers.

Among the 71 total enrollments included in this analysis, consumers were enrolled and receiving ACT services for an average of 354 days. On average, they received four face-to-face service encounters per week for a total average of four hours of face-to-face services per week (see Table 8).

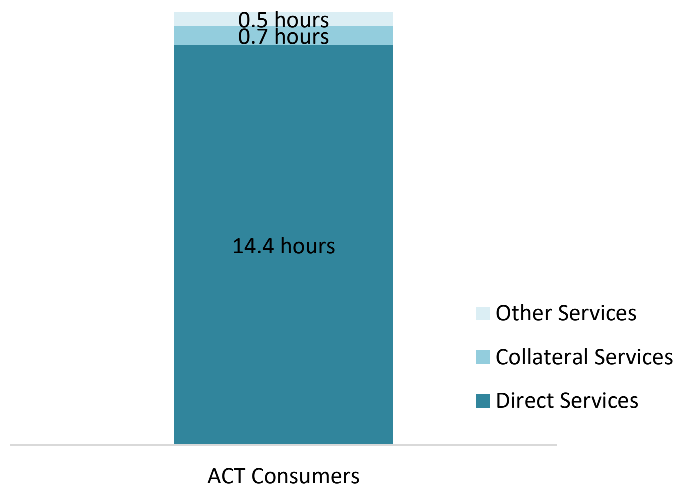
Table 8. ACT Service Engagement (N = 71)

	ACT Consumers	
	Average	*Range*
Length of Enrollment	354 days	33-830 days
Frequency of Service Encounters	4 face-to-face contacts per week	<1 – 13 face-to-face contacts per week
Intensity of Services	4 hours of face-to-face contact per week	<1 – 12 hours of face-to-face contact per week

The ACT team is actively providing direct services to its consumers.

The majority of services provided by the ACT team are direct services to consumers. On average, 92% of service hours logged by ACT providers were direct services to ACT consumers, such as assessment or crisis intervention. A smaller proportion of services were with consumers' support networks or other administrative duties (see Figure 15).

Figure 15. ACT Service Hours per Month



ACT Treatment Adherence and Retention

Two-thirds of ACT consumers (66%) were adherent to ACT treatment during program implementation.

Treatment adherence is defined as consumers agreeing to meet with the treatment team and operationalized as receiving at least one hour of face-to-face engagement with the ACT team a minimum of two times per week. According to this definition, 33% (n = 24) of consumers did not meet this standard of adherence. This may be related to their unwillingness to engage, as well as service unavailability, which may have been impacted by staffing changes in FY 17-18 (see Figure 16 and Figure 17).

Figure 16. Intensity of ACT Contacts per Week

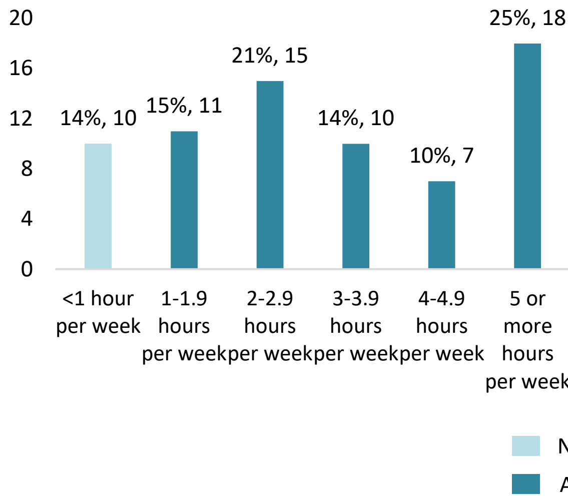
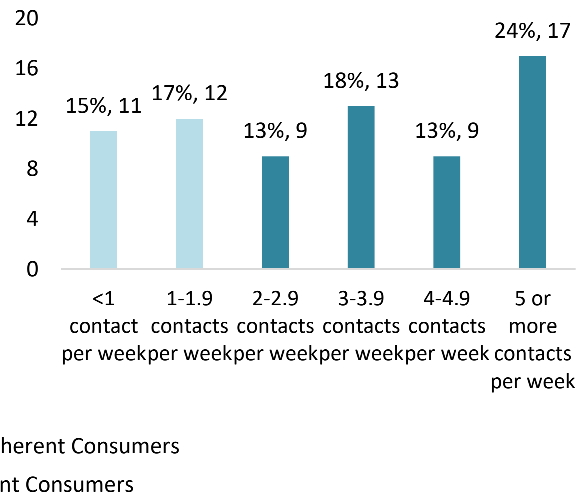


Figure 17. Frequency of ACT Contacts per Week



In order to account for early implementation challenges, which are common when a new program goes through its start-up phase, this treatment adherence definition was also applied only to consumers who enrolled after the first six months of implementation. With individuals from the first six months of implementation removed, the proportion of individuals who were not adherent increased from 33% to 45%. Further, when consumers who enrolled in FY 17-18 were removed from the analysis, the proportion of individuals who were not adherent decreased from 33% to 20%. These differences suggest that the staffing changes that occurred in FY 17-18 may have influenced consumers' ability to meaningfully engage in treatment, resulting in lower adherence rates as specified by this definition.

During this evaluation period, 30 individuals were discharged from the MHS ACTiOn program. Of these 30 individuals, 10 subsequently re-enrolled in the program. Moreover, during this evaluation period, seven consumers (23%) either successfully completed the program or were discharged into a more appropriate level of care, such as conservatorship or a residential treatment program.

ACT Consumer Outcomes

The following sections provide a summary of consumers' experiences with psychiatric hospitalizations, crisis episodes, and homelessness before and during ACT enrollment.

Crisis and Psychiatric Hospitalization

This section describes consumers' crisis stabilization episodes and psychiatric hospitalizations before, during, and after 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.

ACT consumers experienced a significant decrease in both the amount and frequency of crisis episodes and psychiatric hospitalizations during ACT enrollment.

Almost all consumers (91%, n = 61) had at least one crisis episode in the three years before ACT, averaging approximately 3.1 episodes for every six months, with episodes lasting an average of 1.4 days. Fewer

consumers had a crisis episode during their ACT enrollment (52%, n = 35) with an average of 2.2 episodes each six months (see Table 9). Reductions in the proportion of consumers who experienced at least one crisis episode in the three years prior to ACT enrollment and during ACT enrollment are significant[9], suggesting that ACT participants were less likely to experience crisis episodes during AOT enrollment as a result of program participation.

Table 9. Consumers' Crisis Episodes Before and During ACT (N = 67)[10]

	Before ACT Enrollment	During ACT Enrollment
Number of Consumers	91%, n = 61	52%, n = 35
Average Number of Crisis Episodes	3.1 episodes per 180 days	2.2 episodes per 180 days
Average Length of Stay	1.4 days	1.2 days

Similarly, the number of consumers who experienced a psychiatric hospitalization decreased during ACT. Over half of ACT consumers (55%, n = 37) had at least one hospitalization in the three years before ACT, compared to 31% of consumers who experienced a hospitalization during ACT. Those with at least one hospitalization before ACT averaged approximately one hospitalization every six months, lasting approximately seven days each. Although consumers had fewer hospitalizations (0.7 per 180 days) while enrolled in ACT, the average length of stay increased slightly from 7.3 to 10.0 days (see Table 10). Reductions in the proportion of consumers who experienced a psychiatric hospitalization in the three years prior to ACT enrollment and during ACT enrollment are also significant[11], suggesting that ACT participants were also less likely to experience psychiatric hospitalizations during AOT enrollment than prior.

Table 10. Consumers' Inpatient Hospitalizations Before and During ACT (N = 67)

	Before ACT Enrollment	During ACT Enrollment
Number of Consumers	55%, n = 37	31%, n = 21
Average Number of Hospitalizations	1.0 episodes per 180 days	0.7 episodes per 180 days
Average Length of Stay	7.3 days*	10.0 days**
**Average is 12 days if two long-term hospitalizations of over 100 days are retained; ** Average is 24 days if two long-term hospitalizations of over 100 days are retained*		

Over one-third of consumers (n = 13) continued to experience crisis episodes and/or psychiatric hospitalizations after being discharged from ACT.

Among the 30 individuals discharged from ACT, 10 subsequently re-enrolled in the program. Seven consumers (23%) either successfully completed the program or were discharged into a more appropriate level of care, such as conservatorship or a residential treatment program. Findings suggest that the remaining consumers, who often returned to jail, PES, and inpatient hospitalization, may have been

[9] A p-value is used to determine the probability of observed findings being the result of chance. The above finding was statistically significant at a p-value threshold of .01. This indicates that there is less than a 1% likelihood that the observed outcomes are a result of chance.
[10] Three consumers were removed from the analysis because they were enrolled for less than one month.
[11] A p-value is used to determine the probability of observed findings being the result of chance. The above finding was statistically significant at a p-value threshold of .01. This indicates that there is less than a 1% likelihood that the observed outcomes are a result of chance.

discharged prematurely from ACT. In some instances, these individuals completely disengaged from treatment and could not be located. In other instances, the consumers had originally voluntarily enrolled in ACT, and there may have been opportunities to utilize the AOT petition to further compel their participation in the program.

Criminal Justice System Involvement

This section describes consumers' criminal justice system involvement by exploring Sheriff's Office bookings, charges, and jail stay data, which were available for the 36 months prior to ACT implementation through June 30, 2018. Following an arrest, individuals are typically booked into local county jail and remain in jail until released through bail payment or on their own recognizance. 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. Conviction data were not available for this report.

Significantly fewer ACT consumers were arrested and booked during ACT enrollment.

The proportion of ACT consumers who were arrested and booked decreased during ACT from 67% (n = 45) before enrollment to 31% (n = 21) during ACT (see Table 11).[12] While the average number of bookings stayed consistent for ACT consumers, their average length of jail stays decreased from 29 days to approximately 18.5 days.

Table 11. Consumers' Bookings and Incarcerations before and during ACT (N = 67)

	Before ACT enrollment	During ACT enrollment
Number of Consumers	67%, n = 45	31%, n = 21
Average Number of Bookings	2.3 bookings per 180 days	2.4 bookings per 180 days
Average Length of Incarceration	29.0 days	18.5 days

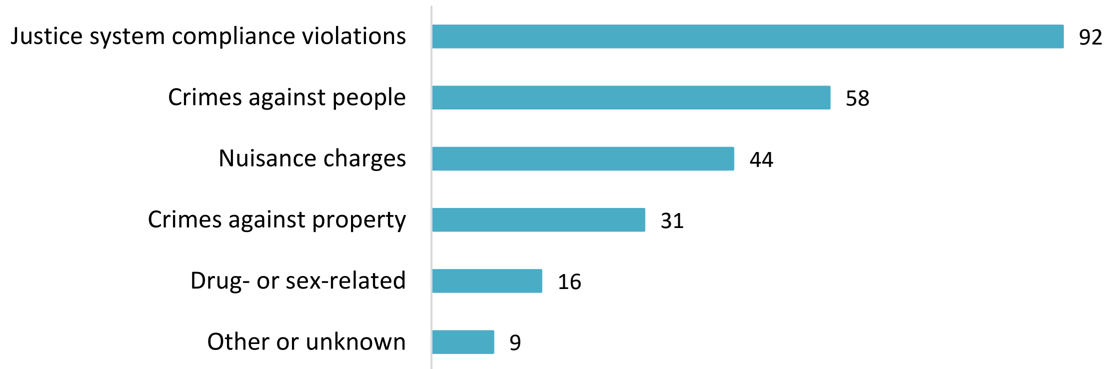
Consumers were often charged with multiple offenses during one booking. Figure 18 categorizes these charges into the following groups:

- **Justice System Compliance Violations**: Charges involving violating probation or other court orders, or obstruction.
- **Crimes against People**: Charges involving assault, battery, robbery, weapons possession, driving under the influence, false imprisonment, or violation of protective orders.
- **Nuisance**: Charges involving trespassing or disorderly conduct.
- **Crimes against Property**: Charges involving arson, theft, burglary, shoplifting, and vandalism.
- **Drug or Sex-Related Crimes**: Charges involving possession of controlled substances, indecent exposure, sexual battery, or soliciting a lewd act.
- **Other or Unknown**: Charges involving driving without a license or a suspended license, fraud, or unknown charge.

[12] A p-value is used to determine the probability of observed findings being the result of chance. The above finding was statistically significant at a p-value threshold of .01. This indicates that there is less than a 1% likelihood that the observed outcomes are a result of chance.

The majority of charges against ACT consumers were for system compliance violations, which were primarily probation violations. The majority of ACT consumers' crimes against people were either assault or battery.

Figure 18. Types of Charges During ACT Enrollment



Housing

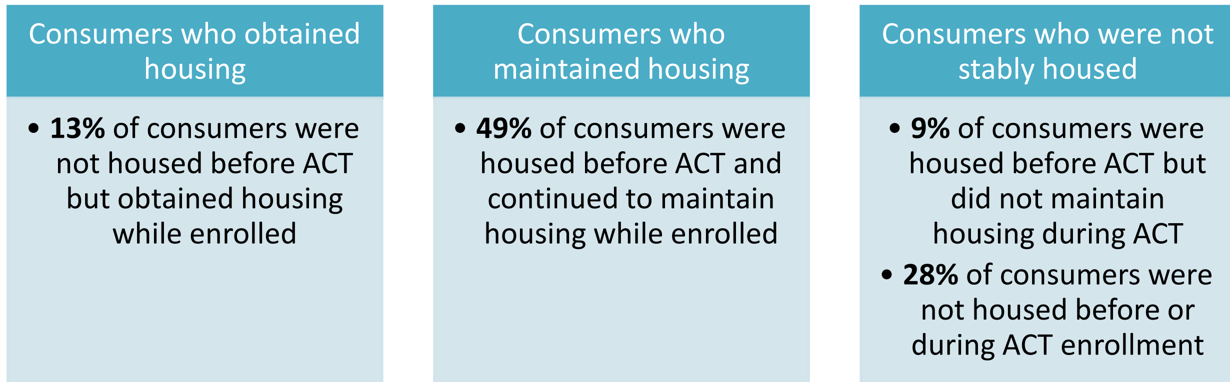
In addition to improving consumers' mental health outcomes, ACT services are also designed to support consumers in attaining suitable housing situations that support their community mental health treatment.

The majority of consumers either obtained or maintained housing while in ACT.

Self-reported housing data were available for 75% (n = 53) of all ACT consumers. Among th3 53 ACT consumers with available housing data, 62% (n = 33) were in stable housing at the conclusion of the evaluation period.[13] RDA compared consumers' baseline housing status to their last known residence as of June 30, 2018 to explore changes in consumers' housing status during ACT enrollment. As shown in Figure 19, 13% (n = 7) of consumers obtained housing while enrolled in ACT, while approximately half (49%, n = 26) maintained the stable housing they had before ACT enrollment. The remaining 37% of consumers either lost their housing while in ACT, or never had nor gained stable housing.

[13] RDA used the Department of Housing and Urban Development (HUD) definition of stable housing to determine which categories from the FSP PAF and KET forms should be considered "housed."

Figure 19. Consumers' Housing Status before and during ACT[14]



Severity of Mental Illness, Self-Sufficiency, and Violent Behaviors

Consumers' abilities to function independently and participate in meaningful activities that are a part of daily living are also of key importance in ACT programs. In order to understand how ACT participation may influence these abilities, this section examines changes in consumers' severity of mental illness (assessed with the BPRS-E instrument), as well as changes in their self-sufficiency across a number of domains (assessed with the Self-Sufficiency Matrix).

ACT consumers experience a significant variety of severe psychiatric symptoms.

To assess the severity of consumers' symptoms, the MHS ACTiOn team administered the BPRS-E instrument with each consumer at the point of intake. The BPRS-E is a rating scale for clinicians to measure psychiatric symptoms and assess treatment changes across a comprehensive set of common symptom characteristics; it rates the severity of consumers' experience of symptoms from one ("not present") to seven ("extremely severe"). Overall, MHS assessed 47 of its 70 consumers at intake with the BPRS-E instrument. The average scores for ACT consumers ranged between 2.9 ("very mild" to "mild") for Activation-related symptoms to 3.6 ("mild") for Positive Symptoms (see Table 12). Some individual consumers scored up to 7 ("extremely severe") on certain domains. On average, ACT consumers demonstrated mild to moderate scores in their psychiatric symptomology at the point of AOT enrollment; but there was a high degree of variation between the minimum and maximum scores for each domain. The domain which the highest proportion of ACT consumers (23%) scoring worse than Moderately Severe was having Positive Symptoms (hallucinations, unusual thought content, suspiciousness, grandiosity).

[14] Due to rounding, percentages do not add up to 100.

Table 12. Baseline BPRS-E Scores (N=47)[15]

Symptom Domains	Subscale Items	Average Score	Minimum Score	Maximum Score	% of Consumers Scoring above Moderately Severe
Affect	Anxiety, guilt, depression, suicidality	3.2	0.5	5.8	9%
Positive Symptoms	Hallucinations, unusual thought content, suspiciousness, grandiosity	3.5	0.3	7.0	23%
Disorganizations	Conceptual disorganization, disorientation, self-neglect, mannerisms-posturing	3.0	0.5	6.0	6%
Negative Symptoms	Blunted affect, emotional withdrawal, motor retardation	3.3	1.0	7.0	13%
Activation	Excitement, motor hyperactivity, elevated mood, distractibility	2.9	0.3	7.0	11%

Legend:	1 = Not Present	2 = Very Mild	3 = Mild	4 = Moderate	5 = Moderately Severe	6 = Severe	7 = Extremely Severe

Overall, the severity of psychiatric symptoms for ACT consumers decreased across most symptom domains during ACT program enrollment.

MHS staff conducted the BPRS-E assessment with 26 ACT consumers at both their AOT intake and six months later (interim). The average scores for all ACT consumers ranged between 2.7 ("very mild") for Activation-related symptoms up to 3.6 for Positive Symptoms (see Table 13). The overall average severity score decreased for all psychiatric symptom domains during ACT program participation. Moreover, the Positive Symptoms domain saw the greatest decrease between intake and six months later in the proportion of ACT consumers who scored worse than moderately severe (decrease from 31% to 15% of ACT consumers).

[15] Data Source: Brief Psychiatric Rating Scale Expanded (BPRS-E)

Table 13. Comparing Changes in BPRS-E Average Scores (N=26)[16]

Symptom Domains	Subscale Items	Intake	Interim	% of Consumers Scoring above Moderately Severe @ Intake	% of Consumers Scoring above Moderately Severe @ Interim
Affect	Anxiety, guilt, depression, suicidality	3.0	2.8	8%	4%
Positive Symptoms	Hallucinations, unusual thought content, suspiciousness, grandiosity	3.6	3.3	31%	15%
Disorganizations	Conceptual disorganization, disorientation, self-neglect, mannerisms-posturing	3.1	3.0	12%	23%
Negative Symptoms	Blunted affect, emotional withdrawal, motor retardation	3.1	2.9	8%	8%
Activation	Excitement, motor hyperactivity, elevated mood, distractibility	2.7	2.4	8%	8%

Legend:	1 = Not Present	2 = Very Mild	3 = Mild	4 = Moderate	5 = Moderately Severe	6 = Severe	7 = Extremely Severe

Across most domains, ACT clients are vulnerable in their abilities to be self-sufficient.

Consumers' ability to be self-sufficient in their daily lives is also of key importance in AOT programs. The Self-Sufficiency Matrix, administered to the ACT clients by MHS, provides information about consumers' social functioning and independent living at intake on a scale from 1 ("in crisis") to 5 ("empowered/thriving"). Intake data was collected for 57 consumers; Table 14 reports the average scores for consumers at their first assessment. On average, consumers scored higher than 3 ("stable") in domains related to health care coverage, life skills, adult education, legal, and safety. The higher scores for these domains may be attributed to consumers achieving sufficient stability and accessing supportive services when discharged from psychiatric hospitals or other mental health facilities prior to enrolling in AOT. Consumers scored lower than 3 ("stable") in domains related to housing, employment, income, food and nutrition, relationships, transportation, community involvement, mental health, substance abuse, and disabilities. The lower scores for these domains indicate the domains in which ACT consumers may need additional support – from the ACT program or elsewhere – in order to increase their own abilities to be more sufficient in those domains.

Table 14. Baseline Self-Sufficiency Matrix Scores (N=57)[17]

Domain	Average Score	Score Description
Housing	2.6	• 2= In transitional, temporary or substandard housing; and/or current rent/mortgage payment is unaffordable (over 30% of income)

[16] Data Source: Brief Psychiatric Rating Scale Expanded (BPRS-E)
[17] Data Source: Self-Sufficiency Matrix (SSM)

Domain	Average Score	Score Description
		• 3= In stable housing that is safe but only marginally adequate
Employment	1.1	• 1= No job
Income	2.0	• 2= Inadequate income and/or spontaneous or inappropriate spending
Food and Nutrition	2.6	• 2= Household is on food stamps • 3= Can meet basic food needs but requires occasional assistance
Adult Education	3.5	• 3= Has high school diploma/GED • 4= Needs additional education/training to improve employment situation and/or to resolve literacy problems to where they are able to function effectively in society
Health Care Coverage	3.9	• 3= Some members (e.g. children) have medical coverage • 4= All members can get medical care when needed but may strain budget
Life Skills	3.0	• 3= Can meet most but not all daily living needs without assistance
Family/Social Relations	2.5	• 2= Family/friends may be supportive but lack ability or resources to help; family members do not relate well with one another; potential for abuse or neglect • 3= Some support from family/friends; family members acknowledge and seek to change negative behaviors; are learning to communicate and support
Mobility/ Transportation	2.5	• 2= Transportation is available, but unreliable, unpredictable, unaffordable; may have vehicle but no insurance, license, etc. • 3= Transportation is available and reliable but limited and/or inconvenient; drivers are licensed and minimally insured
Community Involvement	2.4	• 2= Socially isolated and/or no social skills and/or lacks motivation to become involved
Legal	3.5	• 3= Fully compliant with probation/parole terms • 4= Has successfully completed probation/parole within past 12 months; no new charges filed
Mental Health	2.2	• 2= Recurrent mental health symptoms that may affect behavior but not a danger to self/others; persistent problems with functioning due to mental health symptoms
Substance Abuse	2.9	• 2= Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol; withdrawal or withdrawal avoidance behaviors evident; use results in avoidance or neglect of essential life activities. • 3= Use within last 6 months; evidence of persistent or recurrent social, occupational, emotional or physical problems related to use (such as disruptive behavior or housing problems); problems have persisted for at least one month
Safety	3.4	• 3= Current level of safety is minimally adequate; ongoing safety planning is essential
Disabilities	2.3	• 2= Vulnerable - sometimes or periodically has acute or chronic symptoms affecting housing, employment, social interactions, etc.

Legend:	1 = In Crisis	2 = Vulnerable	3 = Safe	4 = Building Capacity	5 = Empowered

ACT consumers experienced very little change in their self-sufficiency scores during program enrollment.

MHS staff conducted the Self-Sufficiency Matrix (SSM) assessment at AOT enrollment and then six months later with 35 ACT consumers. Table 15 reports the average scores for those consumers at their first assessment and again six months later. On average, ***consumers' scores improved to higher (higher than 3 "stable") in domains related to housing and food and nutrition***. All the other scores remained relatively the same between these two assessment timepoints.

Table 15. Comparing Changes in Self-Sufficiency Matrix Average Scores (N=35)[18]

Domain	Intake Average Score	Interim Average Score	Score Description
Housing	2.9	3.2	• 2= In transitional, temporary or substandard housing; and/or current rent/mortgage payment is unaffordable (over 30% of income) • 3= In stable housing that is safe but only marginally adequate
Employment	1.2	1.3	• 1= No job
Income	2.3	2.4	• 2= Inadequate income and/or spontaneous or inappropriate spending
Food and Nutrition	2.9	3.2	• 2= Household is on food stamps • 3= Can meet basic food needs but requires occasional assistance
Adult Education	3.6	3.5	• 3= Has high school diploma/GED 4= Needs additional education/training to improve employment situation and/or to resolve literacy problems to where they are able to function effectively in society
Health Care Coverage	4.2	4.3	• 4= All members can get medical care when needed but may strain budget
Life Skills	3.2	3.5	• 3= Can meet most but not all daily living needs without assistance
Family/Social Relations	2.6	2.8	• 2= Family/friends may be supportive but lack ability or resources to help; family members do not relate well with one another; potential for abuse or neglect • 3= Some support from family/friends; family members acknowledge and seek to change negative behaviors; are learning to communicate and support
Mobility/ Transportation	2.5	2.8	• 2= Transportation is available, but unreliable, unpredictable, unaffordable; may have vehicle but no insurance, license, etc. 3= Transportation is available and reliable but limited and/or inconvenient; drivers are licensed and minimally insured
Community Involvement	2.6	2.8	• 2= Socially isolated and/or no social skills and/or lacks motivation to become involved • 3= Lacks knowledge of ways to become involved
Legal	3.5	3.6	• 3= Fully compliant with probation/parole terms • 4= Has successfully completed probation/parole within past 12 months; no new charges filed
Mental Health	2.4	2.4	• 2= Recurrent mental health symptoms that may affect behavior but not a danger to self/others; persistent problems with functioning due to mental health symptoms
Substance Abuse	3.1	3.3	• 3= Use within last 6 months; evidence of persistent or recurrent social, occupational, emotional or physical problems related to use (such as disruptive behavior or housing problems); problems have persisted for at least one month
Safety	3.6	3.9	• 3= Current level of safety is minimally adequate; ongoing safety planning is essential • 4= Environment is safe, yet future of such is uncertain; safety planning is important
Disabilities	2.5	2.4	• 2= Vulnerable - sometimes or periodically has acute or chronic symptoms affecting housing, employment, social interactions, etc.

Legend:	1 = In Crisis	2 = Vulnerable	3 = Safe	4 = Building Capacity	5 = Empowered

Few ACT consumers perpetuate violence towards others and/or experience victimization.

MHS implemented the Abbreviated MacArthur Community Violence Tool (MacArthur Tool) to assess changes in violence and victimization of consumers during ACT program enrollment. The MacArthur tool

[18] Data Source: Self-Sufficiency Matrix (SSM)

includes 17 questions that assess the frequency of violence, victimization or perpetration of assaultive behavior by consumers during the last month. Victimization and violent behaviors include behaviors that causes physical or emotional harm to themselves or others. It can range from verbal abuse to physical harm to self, others, or property.

MHS administered the MacArthur Tool with 33 ACT clients. The majority of ACT clients at baseline reported that they had not been victimized nor perpetrated violence towards someone in the month prior to enrollment. However, given the sensitive nature of these questions and that very few individuals reporting experiencing either activity during both timepoints, these results are likely an underrepresentation of these outcomes and should be interpreted with caution.

AOT Costs and Cost Savings

AOT Sources and Expenses

The County's AOT program is funded through a variety of sources. Mental health services provided by CCBHS and MHS are funded by MHSA Community Services and Supports (CSS) and Medi-Cal Federal Financial Participation. Legal costs associated with the program from County Counsel, the Public Defender, and the Superior Court[19] are funded through the County general fund. In FY 17-18, the entirety of the AOT program was budgeted at $2,782,500. However, the actual cost for FY 17-18 was $1,904,132.83. All partners' actual expenses were less than budgeted in FY 17-18, as demonstrated in Table 16. Of the actual expenses, $1,812,919 was funded by MHSA CSS and Medi-Cal FFP funds, and $91,214 came from the County general fund.

Table 16. FY 17-18 AOT Budget and Actual Expenses

Partner	FY 17-18 Budget	FY 17-18 Actual Costs
MHS	$2,014,000	$1,560,080
CCBHS	$350,000	$252,839
County Counsel	$157,000	$32,379
Public Defender	$133,500	$56,250
Superior Court	$128,000	$2,585
Total	**$2,782,500**	**$1,904,133**

For services associated with ACT, it was anticipated that 70% of all services provided would be billable and 35% of the revenue would therefore come from Medi-Cal FFP. According to CCBHS Medi-Cal billing reports, the total billing for FY 17-18 was $383,163 (25% of actual expenses), which is below what was anticipated. There are a number of factors that influence Med-Cal billing and all of the sources of funds

[19] Actual court costs for FY 17-18 were 2% of the budgeted amount, and the court agreed to participate in the program with no funds from the county beginning in FY 18-19.

for the MHS contract are MHSA and FFP, so this difference changes the amount of funding being drawn from the County's MHSA CSS allocation but does not impact the actual cost to the County.

Cost Savings and Avoidance

Mental health and jail costs were calculated for all ACT consumers enrolled in the program (n = 70) to determine the actual cost savings and cost avoidance produced by the AOT program. Pre-enrollment costs were calculated using actual charges from PSP and jail booking data using a projected cost of $106 per consumer per day[20] for the 36 months preceding each individual's enrollment. Post-enrollment data included all PSP and jail data for the entirety of the project period following each individual's enrollment in the AOT program. Given the differences in pre- and post-enrollment timeframes, pre-enrollment costs were standardized to 29 months to allow for direct comparison. Table 17 compares the pre- and post-AOT enrollment cost differences by type of charge.

Table 17. Pre- and Post-Enrollment Cost Comparison

	Pre-Enrollment	Post-Enrollment	Total Difference	Annual Estimate
Outpatient and Residential Mental Health Services	$5,280,971	$3,868,976	$1,411,995	$584,274
Psychiatric Hospitalization	$2,167,051	$1,049,866	$1,117,185	$462,283
Jail Bed Days	$507,722	$194,192	$313,530	$129,737
Total Mental Health Services	$7,448,022	$4,918,842	$2,529,180	$1,046,557
Total Mental Health and Jail	$7,955,744	$5,113,034	$2,842,710	$1,176,294

Overall, the program reduced the total cost of care for the 70 enrolled consumers by $2,842,710 from February 2016 through June 2018 (approximately $1,176,294 per year). However, not all cost reductions resulted in actual cost savings to the County. Of this amount, the AOT program produced a hard cost savings of $1,117,185 over the first 29 months of implementation, which is approximately $462,283 per year. Given that the actual County expenditures for the program in FY 17-18 were $91,214, the program produces an estimated $371,069 of hard cost savings per year. Additionally, the program resulted in cost avoidance from reduced outpatient and residential mental health service costs as well as from a reduction in jail bed days. While these do not reflect actual cost savings to the County, they are representative of an overall reduction in the cost of services for the 70 enrolled consumers.

[20] Grattet, R. and Martin, B. (2015). *Probation in California*. Retrieved on August 24, 2017 from http://www.ppic.org/publication/probation-in-california/.

Discussion

In February 2015, the Contra Costa County Board of Supervisors adopted a resolution to authorize the implementation of AOT for a 36-month pilot project to determine if it would effectively identify, engage, and treat a group of individuals who were previously unable to engage in mental health services and cycling in and out of crisis, hospitals, jails, and homelessness. The County also elected to implement Assertive Community Treatment (ACT), an evidence-based outpatient treatment approach that provides the highest level of outpatient services available in the community for those who need it most. This required contracting with a new service provider, MHS, to deliver ACT services in Contra Cost County. The County's AOT program became operational on February 1, 2016 and accepted its first consumer in March 2016.

One of the important components of the County's AOT program is the investigation, outreach, and engagement process used to connect individuals referred to AOT to the appropriate level of care. At the start of program implementation, fewer individuals than anticipated were enrolled in ACT, and the investigation, outreach, and engagement process was taking longer than expected (on average over three months). While this is a long period of time for individuals suffering from serious mental illness not to be connected to services, it is not too surprising that the process was taking that long given that AOT implementation required not only the development of new cross-system partnerships, but also integration of a new contracted service provider in Contra Costa County. Additionally, at program onset, both CCBHS FMH and MHS staff sought to enroll individuals in ACT on a voluntary basis if possible, and staff were very diligent in their implementation of the court process. However, after acknowledging that individuals referred to AOT continued to suffer during the investigation, outreach and engagement process, the County put steps in place to speed up the pre-enrollment process (for example, CCBHS FMH staff institutionalized processes to review whether individuals referred to AOT should receive an AOT petition on a weekly basis). While the County has implemented many changes to support the investigation, outreach and engagement process, the time from referral to ACT enrollment for all individuals referred to AOT in FY 17-18 remained on average longer than three months.

Although it has taken longer than anticipated to enroll AOT-eligible consumers into ACT, the program is reaching its target population and achieving positive outcomes. Since implementing ACT as the service component of the AOT program, MHS has scored high fidelity to the ACT model each year. MHS has maintained a commitment to supporting ACT consumers despite experiencing staffing issues that resulted in sudden turnover. As a result, fewer ACT consumers have experienced crisis episodes and psychiatric inpatient hospitalizations while enrolled in ACT because of their support commitment.

While ACT participants as a whole are experiencing positive outcomes, some continue to have trouble while enrolled in the program, with a subset of consumers continuing to experience inpatient hospitalizations and justice involvement. In addition, it appears that a number of consumers are discharged from ACT prematurely. Over one-third of consumers that have been discharged from ACT continued to experience crisis episodes and/or psychiatric inpatient hospitalizations, and many were never connected to other services upon discharge. The County should consider what the appropriate criteria for discharge is. The County can then ensure that all consumers who are discharged meet this

criterion, and that concrete steps are in place to connect discharged consumers to an appropriate level of care. This criterion should include determining for which consumers it is appropriate to file a petition through the court to compel a longer tenure of AOT participation.

Question 2 | ACT and AOT Comparison Findings

In 2015, the County elected to implement two complementary but discrete programs, ACT and AOT. ACT is an evidence-based behavioral health program for people with serious mental illness who are at-risk of or would otherwise be served in institutional settings (e.g. hospitals, jails/prisons) or experience homelessness. ACT has the strongest evidence base of any mental health practice for people with serious mental illness, which dates back to the 1970s. When done to fidelity, ACT produces reliable results that decrease consumers' negative outcomes such as hospitalization, incarceration, and homelessness and improve psychosocial outcomes, described above. AOT has a more limited evidence base; while it has been available in some states for longer than in California, its implementation is relatively new (although becoming much more widespread). AOT refers specifically to the legal mechanism by which a judge may mandate or compel a person with serious mental illness to comply with a treatment plan on an outpatient basis. In Contra Costa County, the majority of ACT consumers (77%, n = 54) enrolled voluntarily, without the use of the AOT legal mechanism. A smaller subset of consumers (23%, n = 16) required court involvement, either through an AOT settlement agreement or a court petition, to compel participation in ACT services.

The following section explores what differences may exist between individuals who participate voluntarily and those who participate through AOT court involvement. Specifically, it examines the potential differences in the consumer profile, service patterns, and psychosocial outcomes of these individuals.[21]

Consumer Profile

There are few differences in the demographics and diagnoses between consumers enrolled in ACT voluntarily and those enrolled through the court.

Overall, the voluntary and court-ordered ACT consumer populations are similar. Both groups are mostly male and mostly White. Non-White consumers make up a slightly higher proportion of voluntary consumers (43%) compared to court-involved consumers (38%). Additionally, there is a larger proportion of transition age youth (TAY) in the court-involved population (25%) than the voluntary population (17%). In both groups, the largest proportion of consumers were diagnosed with a psychotic disorder, including schizophrenia and schizoaffective disorders.

While consumers in both groups received comparable amounts of outreach and engagement from MHS, it took more time for the Care Team to enroll court-involved individuals.

[21] Given that the court-involved population is less than 20, this section reports descriptive statistic findings and does not include any inference analysis.

Overall, court-involved and voluntarily enrolled consumers received similar amounts of outreach and engagement services for both themselves and their support networks. As shown in Table 18 below, court-involved consumers received slightly more contact attempts for themselves, while voluntarily enrolled consumers received slightly more collateral contact attempts (i.e., outreach attempts with their families and other providers).

Table 18. Outreach and Engagement Attempts by Consumer Enrollment Type

	All ACT Consumers	Voluntarily Enrolled ACT Consumers	Court-Involved ACT Consumers
Number of Consumers who Received Outreach and Engagement	67	53	15
Average Contact Attempts per Consumer	8.7	8.4	9.3
Average Collateral Contact Attempts per Consumer	2.3	2.5	1.6

Notably, though consumers in both groups received comparable amounts of outreach to get enrolled in ACT services, it took on average almost two more months for court-involved consumers to enroll. From referral to AOT enrollment, voluntary consumers took an average of 96 days to enroll, while court-involved consumers took approximately 151 days.

Service Participation

A larger proportion of court-involved consumers have lower service participation compared to voluntarily enrolled consumers.

As discussed earlier, this evaluation operationalizes treatment adherence as at least one hour of face-to-face engagement with the ACT team at least two times a week. Using this definition, over half (53%) of court-involved consumers included in the analysis were not adherent, while just over a quarter (28%) of those who enrolled voluntarily were not adherent. Figure 20 and Figure 21 below illustrate this difference.

Figure 20. Intensity of ACT Contacts per Week

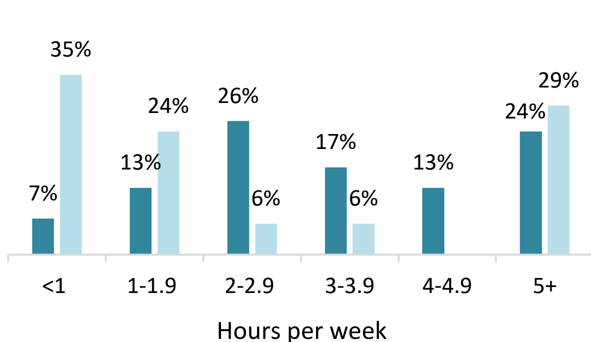
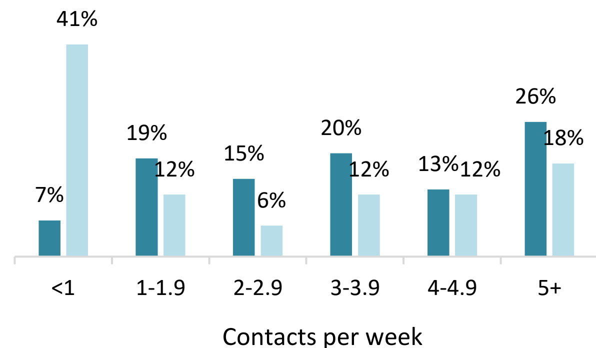


Figure 21. Frequency of ACT Contacts per Week



■ Voluntary ■ Court-Involved

Consumer Outcomes

The following sections provide a summary of voluntarily enrolled and court-involved consumers' experiences with psychiatric hospitalizations, crisis episodes, and housing instability before and during ACT enrollment. It also provides a high-level description of outcomes for a subset of consumers each group who were discharged from ACT.

Consumers who enrolled voluntarily saw a substantial decrease in crisis episodes, inpatient hospitalizations, and criminal justice involvement during ACT.

Among the ACT consumers who enrolled voluntarily, nearly half of the consumers who had at least one crisis experience before enrollment had another crisis experience during enrollment. On average, they experienced one less episode per 180 days during ACT compared to before, and their average length of stay in a crisis facility remained about the same (see Table 19).

A similar trend exists in consumers' inpatient hospitalization experiences. First, the proportion of individuals with a hospitalization before ACT enrollment is similar between the court-involved and voluntarily enrolled consumers. However, a significantly larger proportion of court-involved consumers had a hospitalization during ACT enrollment. As with crisis episodes, the proportion of voluntarily enrolled consumers with at least one hospitalization prior to ACT decreased during their ACT enrollment, from 53% to 24%.

Table 19. Crisis Episodes and Inpatient Hospitalizations Before and During ACT by Enrollment Type

		Before ACT Enrollment		*During ACT Enrollment*	
		Crisis	***Hospitalization***	***Crisis***	***Hospitalization***
Voluntarily Enrolled ACT Consumers (n = 51)	Number of Consumers	90%, n = 46	53%, n = 27	47%, n = 24	24%, n = 12
	Average Number of Episodes	3.2 episodes per 180 days	1.1 episodes per 180 days	2.1 episodes per 180 days	0.8 episodes per 180 days
	Average Length of Stay	1.5 days	13.3 days	1.2 days	25.8 days
Court-Involved ACT Consumers (n = 16)	Number of Consumers	94%, n = 15	63%, n = 10	69%, n = 11	56%, n = 9
	Average Number of Episodes	2.9 episodes per 180 days	0.9 episodes per 180 days	2.7 episodes per 180 days	0.8 episodes per 180 days
	Average Length of Stay	1.3 days	8.1 days	1.2 days	21.3 days

As shown in Table 20, a larger proportion of court-involved consumers were arrested and booked both prior to and during ACT enrollment, compared to voluntarily enrolled consumers.

Table 20. Consumers' Bookings and Incarcerations Before and During ACT by Enrollment Type

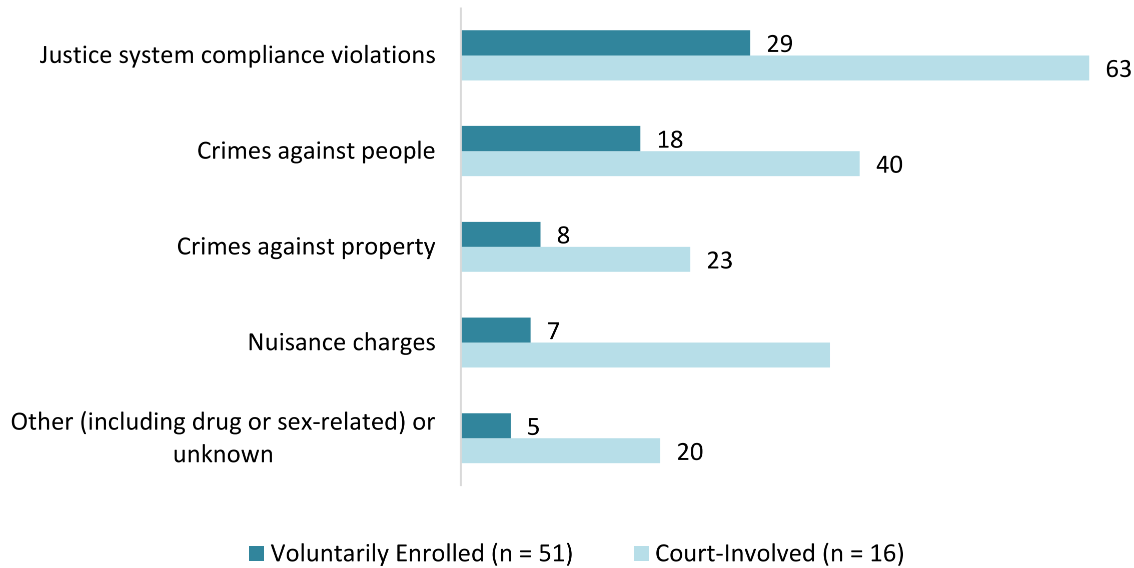
		Before ACT Enrollment	During ACT Enrollment
Voluntarily Enrolled ACT Consumers (n = 51)	Number of Consumers	61%, n = 31	20%, n = 10
	Average Number of Bookings	1.7 bookings per 180 days	0.7 bookings per 180 days
	Average Length of Incarceration	33.7 days	14.4 days
Court-InvolvedACT Consumers (n = 16)	Number of Consumers	88%, n = 14	69%, n = 11
	Average Number of Bookings	3.6 bookings per 180 days	3.9 bookings per 180 days
	Average Length of Incarceration	18.5 days	22.3 days

The disparity in criminal justice outcomes between court-involved and voluntarily enrolled consumers is also apparent in the number and type of charges they received for each booking. Charges were categorized in the following way:

- **Justice System Compliance Violations**: Charges involving violating probation or other court orders, or obstruction.
- **Crimes against People**: Charges involving assault, battery, robbery, weapons possession, driving under the influence, false imprisonment, or violation of protective orders.
- **Nuisance**: Charges involving trespassing or disorderly conduct.
- **Crimes against Property**: Charges involving arson, theft, burglary, shoplifting, and vandalism.
- **Drug or Sex-Related Crimes**: Charges involving possession of controlled substances, indecent exposure, sexual battery, or soliciting a lewd act.
- **Other or Unknown**: Charges involving driving without a license or a suspended license, fraud, or unknown charge.

As shown in Figure 22, while the number of people who were booked and charged during ACT was similar (10 voluntary consumers and 11 court-involved consumers), court-involved consumers were booked more and charged with more offenses.

Figure 22. Types of Charges During ACT by Enrollment Type



A subset of discharged consumers in both consumer groups were likely discharged prematurely.

As of June 30, 2018, eight of the voluntarily enrolled ACT consumers were discharged without re-enrolling in the program. About half of these individuals were likely discharged prematurely, as they could not be found and/or experienced additional inpatient, crisis, and justice episodes following discharge. Among court-involved consumers, a similar trend was observed. Moreover, in both groups, an even smaller portion of discharged consumers either successfully graduated from AOT or were discharged to a more appropriate level of care, such as conservatorship or residential treatment.

A larger proportion of voluntarily enrolled consumers were stably housed compared to court-involved consumers.

The majority of voluntarily enrolled ACT consumers either maintained or obtained stable housing from the time of enrollment to their most recent KET before June 30, 2018. Approximately half of court-involved consumers were able to maintain or obtain stable housing during this period.

Discussion

In 2016, Contra Costa County implemented two complementary but discrete programs, ACT and AOT. ACT has a robust evidence base dating back to the 1970s, and is a service model widely implemented across the nation and internationally. AOT has a more limited evidence base and provides a mechanism to compel treatment for individuals who are unable to engage in mental health services and who are a danger to themselves or others.

All individuals enrolled in Contra Costa County's ACT program were referred to AOT through the County's AOT referral line, however only one-quarter of ACT consumers (23%, n=16) were compelled to treatment through court involvement. There were negligible differences in the demographic characteristics of consumers who enrolled in ACT voluntarily versus those who enrolled with court involvement: both groups were mostly male and mostly White, and the largest proportion of consumers in both groups were diagnosed with a psychotic disorder, including schizophrenia and schizoaffective disorders. The average age of consumers was also similar; however, there is a larger proportion of transition age youth (TAY) in the court-involved population (25%) than the voluntary-enrolled population (17%).

While ACT consumers are mostly similar across demographic characteristics, a greater proportion of court-involved consumers participated in services fewer than two times per week (53%) for less than two hours per week (59%) compared to voluntarily enrolled consumers (26% and 20% respectively). Additionally, the proportion of court-involved AOT consumers who experienced crisis episodes or psychiatric inpatient hospitalizations while enrolled in ACT compared to prior did not significantly decrease, while among consumers who enrolled in ACT voluntarily, the proportion who experienced crisis episodes and psychiatric inpatient hospitalizations significantly decreased while enrolled in ACT because of program participation.

When taken together, these findings indicate that people who enroll in ACT with court involvement have lower levels of participation in the program than those who enroll on a voluntary basis and subsequently experience smaller decreases in crisis and hospitalization than their voluntary counterparts. However, they are more likely to be TAY and have shorter tenures in the program. Given that the County made substantive changes to increase the use of the petition and civil court component of this program in its final year, these analyses should be interpreted cautiously as the lower age of the court-involved group and their shorter tenure in the program may be influencing these results. Regardless, Contra Costa County and MHS should continue to work together to develop strategies to support court-involved ACT consumers so that they are more likely to become adherent to their treatment plans and experience positive outcomes while enrolled in AOT. The County may also wish to consider what role AOT plays in the TAY system of care and how to best leverage this resource to intervene as early on as is possible in the development of serious mental illness.

Question 3 | ACT and FSP Comparison Findings

In this section of the report, RDA compares ACT and AOT consumers with Full Service Partnership consumers (i.e., individuals participating in FSP services) in order to examine the addition of AOT and ACT to the existing system of mental health services, and better understand differences in consumer profiles, service utilization, and outcomes between the County's FSP and ACT/AOT populations. Descriptions of these populations are provided below:

- **FSP consumers** are those individuals who enrolled in and received services from an FSP program. FSP consumers are generally those who are experiencing crisis and hospitalization, incarceration, and/or homelessness and are willing and able to engage in voluntary services without additional support. Generally, these individuals are able to follow through with services enough so as not to require a separate referral or outreach and engagement from a third party or civil court involvement.
- **ACT and AOT consumers** are those individuals who enrolled in and received services from MHS' ACTiOn team voluntarily and those who required civil court involvement to compel participation in MHS' services. For these consumers, a qualified requestor has referred them to the program and FMH and/or MHS has proactively provided outreach and engagement to encourage participation. Unlike FSP, these individuals required additional support to connect to mental health services and had not been successful in accomplishing this independently. However, with assertive outreach and engagement, ACT consumers were able to participate in mental health services voluntarily. Only after civil court compulsion were AOT consumers able to participate in mental health services. Throughout this section of the report, RDA refers to all individuals receiving ACT services through MHS' ACTiOn team (including AOT consumers who only agreed to participate after being compelled through the AOT court mechanism) as ACT consumers, or the ACT population, in order to compare these individuals with the County's FSP population.

The research questions answered in this section include the following:

- What, if any differences exist between those who are able to participate in FSP services versus those who are unable to participate without the additional supports and provisions included within AOT? In other words, are there characteristics that can be identified which explain who may be able more likely to engage in FSP services versus those who are unlikely to engage without AOT?
- What are the differences in services provided by FSP versus ACT? Given that both models are intended to serve similar populations with a flexible, interdisciplinary team, this question will explore the differences in service frequency and intensity of FSP services as compared to ACT.
- What are the differences in outcomes for those who are able to participate in FSP services versus those who are unable to participate without the additional supports and provisions included

within AOT? Given the potential differences in persons served and actual services provided, there may also be differences in outcomes between the two groups that may inform future service designs and/or modifications as well as treatment assignments.

Unless otherwise specified, all ACT consumers (including those enrolled after court involvement) were included in the following analysis. FSP consumers were included if they enrolled in an FSP program on or after the AOT program start date (February 1, 2016).

Consumer Profile

This section provides a summary of the demographic characteristics and diagnoses among the ACT and FSP populations, highlighting key differences across each group.

The FSP and ACT populations are similar across age and gender; however, compared to the FSP population, there is a greater proportion of White consumers and a smaller proportion of Black and Latino consumers enrolled in ACT.

As shown in Table 21, the gender breakdown of ACT and FSP consumers is similar, as is the age breakdown. There are significant differences in the racial and ethnic make-up of each consumer group. Specifically, Black or African American consumers made up a greater proportion of FSP programs (35%, n = 57) than in the ACT program (19%, n = 13).[22] Additionally, White consumers made up a greater proportion of ACT (56%, n = 39) than in the FSP programs (31%, n = 51).

Table 21. Demographic Characteristics of ACT and FSP Consumers

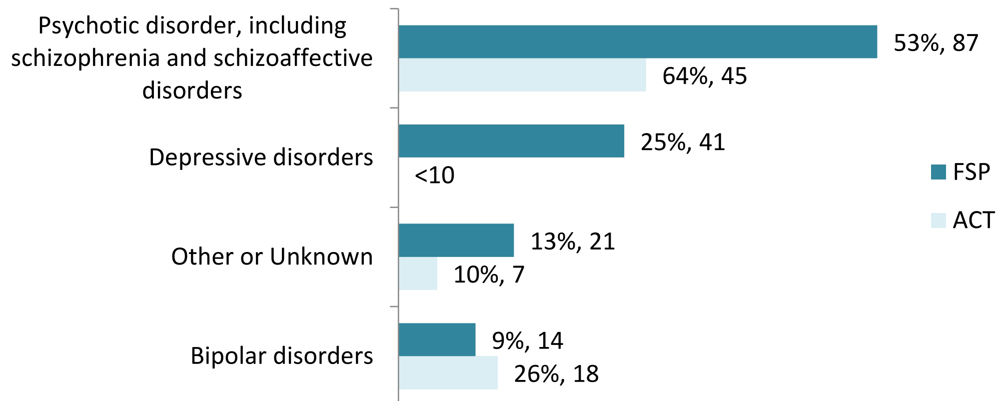
	ACT Consumers (N =70)	FSP Consumers (N = 163)
Gender		
Male	56% (n = 39)	57% (n = 93)
Female	44% (n = 31)	43% (n = 70)
Race and Ethnicity		
Black or African American	19% (n = 13)	35% (n = 57)
Hispanic	16% (n = 11)	19% (n = 31)
White	56% (n = 39)	31% (n = 51)
Other or Unknown	9% (n = 7)	15% (n = 24)
Age at Enrollment		
18 – 25	21% (n = 15)	31% (n = 51)
26 +	79% (n = 55)	69% (n = 112)

ACT consumers were more likely to be diagnosed with a disorder that included psychosis (i.e. psychotic and bipolar disorders) and less likely to be diagnosed with unipolar depression.

[22] This finding was statistically significant at a p-value threshold of .05. This indicates that there is a less than 5% likelihood that the observed outcomes are a result of chance.

Consumers in the FSP programs and ACT program differed in their behavioral health diagnoses. As shown in Figure 23, a significantly larger proportion of ACT consumers were diagnosed with bipolar disorders (25%, n = 18) compared to FSP consumers (9%, n = 14).[23] Additionally, a significantly larger proportion of FSP consumers were diagnosed with depressive disorders (25%, n = 41) than ACT consumers (n < 10).[24]

Figure 23. Mental Health Diagnoses of ACT and FSP Consumers



Overall, almost all ACT (92%) consumers were diagnosed with psychotic or bipolar disorders, compared to 62% of FSP consumers who were diagnosed with psychotic or bipolar disorders at the time of enrollment. These findings suggest that ACT consumers may have had more acute or severe symptoms than FSP consumers at the time of enrollment.

Service Participation

The following section provides a summary of service utilization experiences across the ACT and FSP populations, highlighting key differences in service dosage between each group.

ACT consumers engaged in services more often and for longer durations than FSP consumers.

ACT and FSP consumers were enrolled for similar lengths of time over the course of the evaluation period. As would be expected based on the different service delivery models, consumers enrolled in ACT received, on average, a greater service dosage than consumers enrolled in FSP programs. Over half of all ACT consumers (68%, n = 48) engaged in treatment at least two times per week, for one hour per week, compared to only 38% of FSP consumers (n = 63).[25] On average, ACT consumers received significantly

[23] This finding was statistically significant at a p-value threshold of .05. This indicates that there is a less than 5% likelihood that the observed outcomes are a result of chance.
[24] This finding was statistically significant at a p-value threshold of .001. This indicates that there is a less than 1% likelihood that the observed outcomes are a result of chance.
[25] This finding was statistically significant at a p-value threshold of .001. This indicates that there is a less than 1% likelihood that the observed outcomes are a result of chance.

more face-to-face service contacts (3.8 versus 1.8) for greater durations (3.6 hours versus 2.8 hours) each week.[26] Table 22 provides a summary of these differences.

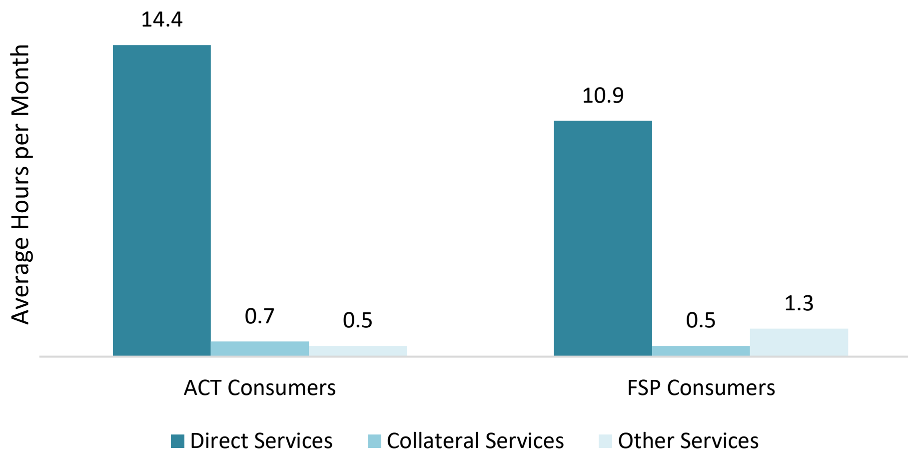
Table 22. ACT and FSP Consumer Service Engagement

	ACT Consumers (N = 71[27])		FSP Consumers (N = 167[28])	
	Average	*Range*	*Average*	*Range*
Length of Enrollment	354 days	33-830 days	400 days	38 – 880 days
Frequency of Service Encounters	3.8 face to face contacts per week	<1 – 13 face-to-face contacts per week	1.8 face-to-face contacts per week	<1 – 8 face-to-face contacts per week
Intensity of Services	3.6 hours of face-to-face contact per week	<1 – 12 hours of face-to-face contact per week	2.8 hours of face-to-face contact per week	<1 – 13 hours of face-to-face contact per week

ACT consumers also received more direct services than FSP consumers.

On average, ACT consumers received significantly more hours of direct service contact per month than FSP consumers. However, FSP consumers received significantly more hours of other types of services, including linkage and advocacy, plan development, or placement services.[29] Figure 24 shows the distribution of the types of services received by ACT and FSP consumers.

Figure 24. Service Hours per Month for ACT and FSP Consumers



[26] This finding was statistically significant at a p-value threshold of .001 for service frequency and .05 for intensity. This indicates that there are a less than 1% and 5% likelihood that the observed outcomes are a result of chance, respectively.
[27] Eight individuals were enrolled in ACT at least once. Their enrollments are counted separately in this analysis. One individual enrolled for less than 30 days was dropped from the analysis. Five individuals enrolled in ACT did not have data available and were not included in the analysis.
[28] Four individuals were enrolled in an FSP twice. Their enrollments are counted separately in this analysis.
[29] These findings were statistically significant at a p-value threshold of .05 and .001. This indicates that there are a less than 5% and 1% likelihood that the observed outcomes are a result of chance, respectively.

Both FSP and ACT providers also deliver services in a variety of settings. ACT and FSP consumers received services in many settings at similar rates, including in-home-based settings (family homes or the unlocked facilities), the field, and clinics. However, ACT consumers received a greater proportion of their services (about 3%) in an institutional setting (i.e., jail or inpatient) than FSP consumers (less than 1%). Additionally, FSP consumers received, on average, a greater proportion of services over the phone (about 22%) compared to ACT consumers (about 17%).

Consumer Outcomes

The following sections provide a summary of ACT and FSP consumers' experiences with psychiatric inpatient hospitalizations, crisis episodes, housing instability, and employment before and during enrollment.[30] These sections also explore the crisis and hospitalization outcomes for ACT and FSP consumers who were discharged from their respective program at least 30 days prior to the end of the evaluation period (June 30, 2018).

Crisis Episodes and Psychiatric Inpatient Hospitalizations

This section describes ACT and FSP consumers' crisis stabilization episodes and psychiatric hospitalizations before, during, and after enrollment. The County's PSP Billing System was used to identify consumers' hospitalizations and crisis episodes in their 36 months prior to enrollment, as well as during and after enrollment.

A greater proportion of ACT consumers experienced adverse outcomes prior to program enrollment compared to FSP consumers.

Almost all ACT consumers (91%, n = 61) experienced at least one crisis episode in the three years before ACT, compared to 75% of FSP consumers (n = 122) who experienced a crisis episode prior to their most recent FSP enrollment. Additionally, over half of ACT consumers (55%, n = 37) experienced a psychiatric hospitalization, compared to 42% (n = 68) of FSP consumers who did in the three years prior to program enrollment (see Table 23). These differences are significant and demonstrate that, compared to FSP consumers, a greater proportion of ACT consumers experienced these outcomes prior to enrollment.[31] Furthermore, ACT consumers who had a crisis episode and/or hospitalization experienced them more often than FSP consumers.

[30] Housing stability and employment were key measures that CCBHS wanted to explore with this AOT evaluation.
[31] This finding was statistically significant at a p-value threshold of .05. This indicates that there is a less than 5% likelihood that the observed outcomes are a result of chance.

Table 23. ACT and FSP Consumers' Crisis Episodes and Psychiatric Hospitalizations Before and During Program Enrollment[32]

ACT Consumers (N = 67)				
	Before ACT Enrollment		***During ACT Enrollment***	
	Crisis	*Hospitalization*	*Crisis*	*Hospitalization*
Number of Consumers	91%, n = 61	55%, n = 37	52%, n = 35	31%, n = 21
Average Number of Episodes	3.1 episodes per 180 days	1.0 episodes per 180 days	2.2 episodes per 180 days	0.7 episodes per 180 days
Average Length of Stay	1.4 days	7.6 days	1.2 days	10.0 days**
FSP Consumers (N = 163)				
	Before FSP Enrollment		***During FSP Enrollment***	
	Crisis	*Hospitalization*	*Crisis*	*Hospitalization*
Number of Consumers	75%, n = 122	42%, n = 68	43%, n = 70	19%, n = 31
Average Number of Episodes	1.5 episodes per 180 days	0.6 episodes per 180 days	2.3 episodes per 180 days	0.9 episodes per 180 days
Average Length of Stay	1.2 days	8.5 days*	1.2 days	8.1 days**
**Average is 12 days if two long-term hospitalizations of over 100 days are retained; ** Average is 24 days if two long-term hospitalizations of over 100 days are retained*				

The proportion of both ACT and FSP consumers experiencing crisis episodes and psychiatric hospitalization, as well as the frequency of those experiences, decreased during enrollment.

As noted previously, a smaller proportion of ACT consumers experienced a crisis episode (52%) or psychiatric hospitalization (31%) while enrolled in ACT compared to their three years prior to ACT enrollment. The same is true for FSP programs, which also saw reductions in the proportion of consumers experiencing crisis episodes (43%) and psychiatric hospitalizations (19%) while enrolled in FSP compared to prior. These reductions in the proportions of consumers who experienced at least one crisis episode or hospitalizations are significant, suggesting that ACT and FSP participants were less likely to experience these outcomes while enrolled because of program participation and not by chance.

During enrollment, ACT consumers had comparable crisis experiences to FSP consumers, suggesting that the intensive services ACT consumers receive are effective and have the potential to support ACT consumers in reaching a level of stability similar to FSP consumers.

While a slightly higher percentage of ACT consumers (52%) than FSP consumers (43%) experienced crisis episodes while enrolled in ACT or FSP, these differences were not statistically significant. This indicates that the differences may be a result of chance. Thus, we cannot conclude that ACT consumers are more likely than FSP consumers to experience crisis while enrolled in outpatient mental health services. This could suggest that ACT participation is supporting consumers to reach a level of stability similar to FSP

[32] Three consumers were removed from the analysis because they were enrolled for less than one month.

consumers during program enrollment. However, it is worth noting that a significantly greater proportion of ACT consumers continued to experience psychiatric hospitalizations during enrollment in comparison to FSP consumers.

A group of ACT and FSP consumers appear to have been discharged prematurely without being connected to an appropriate level of care.

As of June 30, 2018, among the 30 ACT consumers and 43 FSP consumers who were discharged prior to the end of the evaluation period, only 10 ACT consumers and 11 FSP consumers had new episode openings. This is of concern because anyone discharged from ACT or FSP programs may continue to need professional support and should be connected to an appropriate level of care within 30 days. Among the 10 ACT consumers with at least one episode opening after discharge, seven (70%) continued to experience crises and/or psychiatric hospitalizations after discharge before getting connected with other services. Discharged FSP consumers experienced better outcomes, as only three (27%) cycled in and out of crisis episodes without being connected to services.

Housing Status

In order to reliably compare housing outcomes for individuals enrolled in ACT and an FSP program, all providers submitted a point-in-time Key Event Tracking (KET) form that documented consumers' housing status at the time of enrollment and again during the period of July 1 – August 15, 2018.

For the AOT population, at the point of AOT enrollment, 35% (n=19 of 55)[33] of consumers reported experiencing homelessness in the prior 12 months. These AOT consumers reported being homeless for an average of 8.0 months out of the prior 12 months. Between consumers' AOT enrollment and July 1 – August 15, 2018, there was an 18% reduction in AOT consumers experiencing homelessness.

For the FSP population, at the point of FSP enrollment, 45% (n=115 of 257) of consumers reported experiencing homelessness in the prior 12 months. These FSP consumers reported being homeless for an average of 7.5 months out of the prior 12 months. Between consumers' FSP enrollment and July 1 – August 15, 2018, there was a 23% reduction in FSP consumers experiencing homelessness.

Compared to the AOT consumers served by the MHS ACT program, FSP consumers appear to exhibit the following homelessness patterns (see Table 24):

- Similar homelessness patterns (35% of AOT consumers, 45% of FSP consumers); and
- Similar lengths of homelessness in the year prior to program enrollment (8.0 months for AOT clients, 7.5 months for FSP clients).

[33] The point-in-time KET forms were completed between July 1 – August 15, 2018, which is after this report's evaluation period (February 1, 2016 – June 30, 2018). Because of this discrepancy, data was received and included for two additional AOT clients for whom data were not available during the evaluation window.

Table 24. Homelessness Measures for AOT and FSP Clients

Homelessness Measures	AOT Consumers	FSP Consumers
Homeless at some point in 12 months prior to program enrollment (% Y/N)	35%	45%
Length of homelessness in 12 months prior to program enrollment (# of months)	8.0 months	7.5 months
Homeless at some point in 30 days prior to program enrollment (% Y/N)	41%	45%
Homeless at some point during July 1 – August 15, 2018 (% Y/N)	23%	22%

Employment

For the AOT population, at the point of enrollment, less than 10% of AOT consumers reported having employment at some point in the prior 12 months. These AOT consumers reported being employed for an average of 26.0 weeks out of the prior 12 months, for an average of 24.3 hours per week. Between consumers' AOT enrollment and July 1 – August 15, 2018, there is a 16% increase in consumers having employment, with a corresponding average increase of 8.5 hours per week of employment.

For the FSP population, at the point of enrollment, 18% (n=46 of 258) of FSP consumers reported having employment at some point in the prior 12 months. These FSP consumers reported being employed for an average of 18.7 weeks out of the prior 12 months, for an average of 22.4 hours per week. Between consumers' FSP enrollment and July 1 – August 15, 2018, there is a 14% decrease in consumers having employment, with a corresponding average decrease of 2.8 hours per week of employment.

Compared to the AOT consumers served by the MHS ACT program, FSP consumers appear to exhibit the following employment patterns (see Table 25):

- Increased employment prior to program enrollment (<10% of AOT clients, 18% of FSP clients);
- Shorter lengths of employment prior to program enrollment (26.0 weeks for AOT clients, 18.7 weeks for FSP clients); and
- Decreases in employment during program enrollment (16% increase for AOT clients, 11% decrease for FSP clients).

Table 25. Employment Measures for AOT and FSP Consumers

Employment Measures	AOT Consumers	FSP Consumers
Employed at some point in 12 months prior to program enrollment (% Y/N)	<10%	18%
Length of employment in 12 months prior to program enrollment (# of weeks)	26.0 weeks	18.7 weeks

Employment Measures	AOT Consumers	FSP Consumers
Average amount of employment in 12 months prior to program enrollment (hours/week)	24.3 hours/week	22.4 hours/week
Employed at some point in 30 days prior to program enrollment (% Y/N)	<10%	18%
Employed at some point during July 1 – August 15, 2018 (% Y/N)	21%	7%
Average amount of employment in 30 days prior to program enrollment (hours/week)	16.5 hours/week	20.0 hours/week
Average amount of employment in July 1 – August 15, 2018 (hours/week)	25.0 hours/week	17.2 hours/week

Discussion

RDA sought to better understand Contra Costa County's ACT implementation as related to the effectiveness of the County's FSP programs by comparing outcomes of ACT and FSP consumers, respectively. First, RDA assessed whether there were significant differences between each population at the time of enrollment. Next, they assessed whether there were differences in patterns of service receipt. Lastly, differences in consumer outcomes were assessed.

As expected, findings demonstrated that at the time of program enrollment, ACT consumers exhibited more severe psychiatric symptoms than FSP consumers. A significantly greater percentage of ACT consumers (92%) than FSP consumers (62%) were diagnosed with psychotic or bipolar disorders at enrollment, and significantly greater proportions of ACT consumers experienced crisis episodes (91%) and psychiatric inpatient hospitalizations (55%) than FSP consumers (75% and 42%, respectively) in the three years prior to program enrollment.

As would be expected based on the two different service delivery models, individuals enrolled in ACT received more intense services than individuals enrolled in an FSP program. On average, ACT consumers received significantly more service contacts for greater durations than FSP consumers each week, of which a greater proportion were also for direct services (as opposed to collateral or some other type of services). For both populations, services had the intended effects, as ACT and FSP consumers both experienced significant reductions in crisis and hospitalization episodes during program enrollment. The intensive services that ACT consumers received appear to be more effective than FSP services, since ACT consumers generally experienced greater improvements in their psychiatric symptoms. This was evidenced by ACT consumers achieving a level of stability similar to FSP consumers, despite starting out significantly less stable prior to enrollment.

As is the case with ACT consumers, there appears to be a group of FSP consumers who are discharged prematurely, and not immediately connected with appropriate services. As a result, some of these consumers continue to experience crisis and hospitalization without receiving regular outpatient treatment for their mental health condition. The County should consider what potentially more appropriate discharge criteria would be for both FSP and ACT consumers. The County could then explore ways to ensure that all consumers who are discharged from either program type meet these criteria, and that concrete steps are in place to connect discharged consumers to an appropriate level of care. This criterion should include determining for which consumers it is appropriate to file an AOT petition through the court to compel participation in outpatient mental health services.

Summary of Findings

Program Development and Continuous Quality Improvement

Prior to the decision to implement AOT, the County and stakeholders worked together to consider and design a program that would meet the needs of people with the most serious mental illness who were "falling through the cracks." As a result of these efforts, the Board of Supervisors directed County departments to implement ACT and AOT, which combined a new service model and a civil court process. In the initial stages of implementation, County agencies collaborated on the new processes and procedures required to support the referral and investigation process as well as the court component. As with any new program in its formative stages, there were unanticipated challenges along the way that the County and stakeholders worked together to address, including how to:

- Ensure that qualified requestors had the knowledge and resources to make appropriate referrals to the program for individuals most in need;
- Reduce the length of time from referral to enrollment, particularly for those individuals who were continuing to experience crisis, hospitalization, and incarceration and/or homelessness during the investigation and outreach process;
- Determine the most efficient and effective ways for FMH and MHS to work together on referred individuals, engage them in care, and identify the need for a petition, where indicated; and
- Discern the appropriate use of the petition and benefit of the civil court component to encourage participation in ACT services.

While the County and partners worked diligently to identify and resolve these issues as they arose, the net impact early on in the process was that not all qualified requestors were equipped to do so, enrollment in the program took longer than expected for eligible individuals, and there was hesitation to implement the court component. This resulted in a lower census than originally estimated despite a continued perception of need for these high-end services. Along the way, the County and partners sought to proactively identify and address issues as well as seek input from stakeholders, elected officials, and the evaluation team as to how they might continuously improve the program. Their efforts included:

- A renewed effort to provide educational presentations and training to the entirety of qualified requestors, with a particular focus on law enforcement, linking police with the CORE teams to ensure that any beat police officer could connect with a provider from CORE to refer eligible individuals;
- Attendance at weekly case rounds at Contra Costa Regional Medical Center for PES and Unit 4C to identify potential AOT candidates, as well as partner on discharge planning for referred and enrolled consumers;
- A change from a concurrent to a consecutive pre-enrollment phase whereby FMH conducted the referral and investigation process to determine eligibility prior to engaging MHS; and

- A new set of monitoring and communication practices for FMH to continuously review referred and enrolled individuals throughout the referral and investigation, outreach and engagement, and voluntary ACT service enrollment phases and ensure that those individuals who require or would benefit from the civil court component have a petition filed.

These investments in ongoing continuous quality improvement have increased the diversity of qualified requestors, shortened the length of time from referral to enrollment, more swiftly implemented the court component for those who require that level of support, and ultimately increased the number of consumers who are enrolled in and benefitting from the program. While each of these issues has been cause for concern at different times, the commitment of the County, partners, and stakeholders to openly and honestly raise these issues and implement process improvements is what has supported this program to grow to its present capacity. As has been seen across California, AOT programs take time to launch and mature despite the high level of need for these services. In almost every County across California who implemented AOT, the time to launch the program took longer than expected and initial enrollment numbers were lower than expected. Contra Costa County's commitment to this program and the investment in continuous quality improvement is something that should be recognized, appreciated, and preserved.

Service Delivery

ACT Fidelity

ACT has one of the strongest evidence-bases of any mental health intervention for reducing crisis and hospitalization, incarceration, and homelessness for those with the most serious mental illness when performed to fidelity. One component of this program evaluation was to engage in ACT fidelity monitoring in order to support ACT implementation in the County as well as ensure that outcomes observed in the program were not influenced by fidelity issues. In other words, regular fidelity monitoring ensured that evaluation findings could be attributed to AOT and AOT implementation rather than ACT fidelity issues. While the ACT team did experience some challenges early on with recruitment and hiring and understanding that the use of AOT and the civil court component was in alignment with the ACT model, as well as the staff turnover in early-2018, they continued to score in the high-fidelity range across all three annual fidelity assessments. Additionally, they implemented all recommended programmatic improvements suggested in the fidelity assessments to further align the program with the evidence-based model. In comparison to other counties, not all counties are implementing ACT as the service component of AOT, and many counties who have ACT programs do not engage in fidelity monitoring to ensure that their ACT programs are delivered in alignment with the model and producing the expected outcomes. Contra Costa County's commitment to implementing this level of service to fidelity ensures that consumers with the highest level of need who enroll in the program, either voluntarily or through civil court involvement, have access to evidence-based interventions with the highest likelihood of being effective. As seen through the outcomes in preceding sections, this investment has clearly made a difference for the consumers who had access to these services, their families, and their communities.

Length of Tenure

The ACT model is designed to be time-unlimited and allows for consumers to participate in the program for as long as is needed, and the California Welfare and Institutions Code allows for a judge to enter into a settlement agreement or issue a court order for AOT in six-month increments. Research suggests people participating in AOT generally experience reductions in crisis and hospitalization, incarceration, and homelessness during the program and that these benefits are more likely to continue after discharge from AOT if the consumer participates in AOT for at least 12 months, regardless of whether or not they continue to participate in mental health services on an outpatient basis. In Contra Costa County, the average length of enrollment in ACT and AOT is approximately one year, although there is a proportion of consumers who participated for less than 12 months. If the County continues to provide ACT and AOT, it may be useful to consider how to best keep individuals engaged and enrolled for at least 12 months, if not longer, in order to preserve the benefits arising from service participation. To this end, the County may need to determine if there are any barriers to service authorization or court processes that would preclude consumers from receiving the maximum benefit from their time in the program.

Symptoms versus Negative Outcomes

One of the primary reasons that the County implemented AOT was to address the needs of those with the most serious mental illness who were unable and/or unwilling to participate in mental health services and were continuing to experience crisis and hospitalization, incarceration, and/or homelessness. This included a desire to reduce symptoms, improve quality of life, and address issues related to public safety. It is interesting to note that while the program did succeed in reducing crisis and hospitalization, incarceration, and homelessness, the level of symptoms experienced by individuals remained relatively static as did measures of self-sufficiency and violence and victimization. This means that the combination of ACT and AOT was able to successfully support individuals with the most serious mental illness in the community and reduce experiences of crisis and hospitalization, incarceration, and homelessness without reducing symptoms or other mental health indicators. To this end, the County has demonstrated that it has the capacity to successfully support the target population within the community using ACT and AOT and reduce experiences of confinement.

Level of Care Impressions

Full Service Partnership and Assertive Community Treatment

When the County elected to implement ACT, in addition to AOT, a new level of service became available that was more intensive than FSP programs and could be easily combined with the AOT civil court component. Early on, there were questions about how FSP differed from ACT and if both types of programs could be expected to serve the same types of consumers with similar rates of success. Based on the County’s experience over the past three years, it has become clear that:

1. FSP and the ACT programs are serving different consumer groups. While both FSP and ACT consumers have a serious mental illness, ACT consumers are more likely to have a psychotic disorder. Additionally, while FSP and ACT consumers have experiences of crisis and hospitalization, ACT consumers experience higher rates of crisis and hospitalization prior to enrollment.
2. FSP and ACT provide different levels of service. The amount of service provided is higher for the ACT team than FSP programs. The ACT team also receives a higher level of funding to provide this additional service.
3. FSP and ACT teams produce similar outcomes when consumers are in the correct level of care. FSP and ACT consumers alike experience reductions in crisis and hospitalization, incarceration, and homelessness as a result of participating in the programs. However, there are a number of ACT consumers who were originally enrolled in FSP and were referred to the ACT team as a result of needing a more intensive program and/or the civil court component.

Given the data resulting from this evaluation and the entirety of the County's experience over the past three years of implementation, it may be useful for the County to develop data-informed benchmarks to support level of care decisions regarding FSP and ACT. While the consequences are minimal for referring someone to ACT who could otherwise improve or maintain with FSP, the consequences of referring someone to FSP who really actually requires ACT to remain in the community are impactful. Specifically, the County may wish to consider developing guidance based on individuals' level of crisis and hospitalization to better inform whether they should be referred to FSP or ACT services.

AOT and the Use of Petition

Across the state and nation, there has been a renewed discussion about how to best: 1) support individuals with the most serious mental illnesses; 2) interrupt the repetitive cycle of crisis and hospitalization, incarceration, and/or homelessness; and 3) compel participation in outpatient mental health services for those who are unable and/or unwilling to participate on a voluntary basis but do not meet criteria for involuntary services. In order to address this issue, the County elected to implement both ACT and AOT.

At the beginning of program implementation, there appeared to be agreement that voluntary service participation was preferred when possible, and that the use of the court petition should be reserved for those who would not consent to services on a voluntary basis despite the program's best efforts to do so. This led to an investment of time and resources with referred individuals to obtain their voluntary participation in ACT services and prolonged the amount of time from referral to enrollment. Specifically, the data showed that:

- Referred individuals were continuing to experience crisis and hospitalization, incarceration, and/or homelessness post-referral and that it may be useful to file a petition sooner in order to interrupt these experiences; and
- Some portion of consumers who enrolled on a voluntary basis were not benefiting from the program as expected, and a petition may be useful to compel more consistent participation,

prevent premature discharge, and reduce the experiences of crisis and hospitalization, incarceration, and/or homelessness.

As a result of these learnings, the County and partners worked together to establish mechanisms to review whether or not a petition would be useful on a monthly basis during the investigation and outreach periods as well as implementing a review of consumers who enrolled on a voluntary basis and continued to struggle with crisis and hospitalization, incarceration, and/or homelessness. Across the state, some counties have also struggled with the tension between voluntary service participation for those who were able to do accept and participate in outpatient mental health services and those who require a petition and civil court involvement to do so. Contra Costa County's ability to swiftly engage in process improvements based on evaluation findings and stakeholder feedback has resulted in an increased use of the petition for those who require that level of support and has ultimately helped more individuals engage in medically necessary mental health services more quickly.

Conclusion

Overall, this evaluation documents Contra Costa County's efforts to serve individuals with the most serious mental illnesses in the community using evidence-based practices and interventions. Across all of the interim evaluation reports and continuing through this evaluation period, it is clear that people who participate in ACT and AOT experience benefits, specifically in reducing experiences of crisis and hospitalization, incarceration, and homelessness. While the program took longer than originally anticipated to get started and there were challenges to address along the way, the County and its partners worked diligently over the pilot period to strengthen the program and ensure that those individuals most in need had access to services that were likely to help them. If the County extends the approval of these investments in ACT and AOT, it will be important to continue to monitor the program and make adjustments informed by the data gathered and lessons learned to ensure that the program and investments continue to produce the expected results for consumers, their families, and the community.

Appendices

Appendix I. AOT Eligibility Requirements[34]

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.

[34] Welfare and Institutions Code, Section 5346

Appendix II. MHS' ACTiOn Team 2018 Fidelity Assessment Report

Introduction

As an evidence-based psychiatric rehabilitation practice, Assertive Community Treatment (ACT) provides a comprehensive approach to service delivery to consumers with serious 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 to 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.[35] 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.

[35] 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 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[36] and codified in a SAMHSA toolkit.[37] 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 the requisite qualifications for assessors.

Roberta Chambers, PsyD, and Jamie Dorsey, MSPH, 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 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 June 20, 2018. During the site visit, the assessors engaged in the following activities:

- ACT team meeting observation
- Interviews with eight (8) ACT team members
- Review of available documentation
- Consumer focus group
- Family member focus group
- Debrief with the ACT team

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 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.

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

[37] 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 the MHS ACTiOn team's 2017 and 2018 program ratings. As shown in the table below, **the MHS ACTiOn team received an overall fidelity score of 4.50 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	2017 Rating	2018 Rating
Human Resources: Structure and Composition	Small caseload	5	5
	Team approach	4	5
	Program meeting	5	5
	Practicing ACT leader	4	5
	Continuity of staffing	3	4
	Staff capacity	4	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	2	5
	Intake rate	5	5
	Full responsibility for treatment services	5	5
	Responsibility for crisis services	5	5
	Responsibility for hospital admissions	5	1
	Responsibility for hospital discharge planning	5	5
	Time-unlimited services	5	5
Nature of Services	In vivo services	3	4
	No drop-out policy	3	5
	Assertive engagement mechanisms	2	5
	Intensity of services	5	4
	Frequency of contact	4	3
	Work with support system	5	5
	Individualized substance abuse treatment	5	3
	Co-occurring disorder treatment groups	5	3
	Co-occurring disorders model	5	5

Domain	Criterion	2017 Rating	2018 Rating
	Role of consumers on treatment team	5	5
ACT Fidelity Score		**4.42**	**4.50**

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 at they have 9.5 FTEs who provide direct services, as well as two administrative staff, for 49 active consumers, which exceeds the 10:1 consumer-to-provider ratio. This was assessed through personnel records and staff interviews.

Team Approach: 5

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 5 for this criterion as more than 90% 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 team meeting observation, staff interviews, and consumer and family focus groups. *This is an increase from the 2017 rating of 4 when 70% of consumers had face-to-face interactions with more than one team member in a two-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 the 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 the program meeting through available documentation and staff interviews.

Practicing ACT Leader: 5

Practicing ACT leader refers to the supervisor of frontline staff providing direct service to consumers. MHS' ACTiOn team received a rating of 5 as the Team Leader spends at least 50% of their time providing direct services to consumers. The rating was assessed through staff interviews and was supported through the team meeting observation, review of consumer records, and consumer and family focus groups. *This rating is an increase from the 2017 rating of 4 when the Team Leader spent approximately 30% of their time providing direct services. It is important to note that the MHS ACTiOn team had significant changes in leadership during the past year, including a new Team Leader.*

Continuity of Staffing: 4

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, 10 staff discontinued employment with MHS' ACTiOn team, resulting in a 36% turnover rate. As the turnover rate falls within the range of 20-39%, the rating for this measure is 4. The turnover rate was assessed through a review of personnel records and staff interviews. *This rating is an increase from the 2017 rating of 3, when there was a 47% turnover rate.*

Staff Capacity: 4

Staff capacity refers to the ACT program operating at full staff capacity. Full fidelity requires the program to operate at 95% or more of full staff capacity over the last 12 months. According to personnel records, MHS' ACTiOn team operated at 82% of full staff capacity over the previous year, resulting in a rating of 4 as it falls within the range of 80-90%. Although the ACTiOn team also received a rating of 4 in 2017, there was a slight decrease in staff capacity from 2017 where the team operated at 94% staff capacity during the evaluation period. The reduced staff capacity reflects staff transitions and turnover in the past year due to changes in MHS ACTiOn team leadership.

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 49 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 0.75 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 one full-time licensed vocational nurse (LVN) for the 49 active consumers, as observed by personnel records and staff interviews. This exceeds the required ratio and results in a rating of 5. The ACT model does not specify the level of nursing required in terms of Registered Nurse (RN) versus LVN or Licensed Psychiatric Technician (LPT); however, there are differences in scope of practice between an RN and LVN or LPT in California. In previous years, the ACTiOn team has included an RN as a part of the team, although the position is currently vacant. While additional nursing is not required for up to 50 consumers, the ACTiOn team may wish to consider hiring an RN as the second nursing position as the program increases enrollment.

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 1.0 FTE substance abuse specialist for the 49 active consumers, as observed by personnel records and staff interviews. This meets the required ratio, given there are 49 active consumers and results in a rating of 5. Once the program is at full capacity of 75 enrolled consumers, the team will require at least 1.5 FTE with the requisite experience in substance abuse to meet full fidelity to the ACT model.

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. MHS' ACTiOn team includes 1.0 FTE who meet criteria for a vocational rehabilitation specialist, as observed by personnel records and staff interviews. This meets the required ratio for 49 enrolled consumers and results in a rating of 5. Once the program is at full capacity of 75 enrolled consumers, the team will require at least 1.5 FTE with the requisite experience in training or experience in vocational rehabilitation and support to meet full fidelity to the ACT model.

Program Size: 5

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

Organizational Boundaries

Explicit Admission Criteria: 5

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. Although the responsibility for identifying and engaging potential ACT consumers lies primarily with CCBHS as part of the larger AOT program, MHS also independently outreaches to and assesses referred individuals for ACT criteria and works closely with CCBHS to reach consensus around who should be enrolled in the program. This results in a rating of 5, which was assessed through staff interviews and program documentation. *The rating demonstrates significantly improved collaboration between CCBHS and the MHS ACTiOn Team during the admission process, represented by a substantial increase from the 2017 rating of 2, when MHS accepted referred consumers they did not believe met criteria.*

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. This was assessed through consumer records and staff interviews.

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, resulting in a rating of 5. This was observed through team meeting observation, staff interviews, a review of consumer records, and input from consumer and family focus groups.

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 results in a rating of 5, which was assessed through staff interviews, team meeting observation, and input from the consumer focus group.

Responsibility for Hospital Admissions: 1

The ACT model includes the ACT team participating in decision-making for psychiatric hospitalization. The MHS ACTiOn team is willing and available to participate in all decisions to hospitalize consumers. However, this requires that hospitals and emergency departments are 1) aware that a consumer is enrolled in ACT, and 2) willing to involve the ACT team in the decision-making process. ACTiOn team members shared that when possible, they share their opinion of whether a consumer should be hospitalized when arriving with a consumer at PES. However, the ACTiOn team noted that PES does not meaningfully involve the MHS ACTiOn team in the decision-making process and typically only notifies the ACTiOn team when the consumer has already been hospitalized or is being discharged from PES. This removes a key function of the ACT program to intervene with consumers and reduce associated hospitalizations and results in a rating of 1. *This rating represents a marked decrease from the 2017 rating of 5. As noted previously, the MHS ACTiOn team experienced significant staff turnover and changes in leadership during the past year, and it is unclear if the lower rating reflects changes in hospital admission processes or differences in how ACTiOn team leadership describes the hospital admission process. Nevertheless, MHS shared that they are*

currently working with CCBHS to strengthen collaboration with PES to improve communication and shared decision-making for PES discharge and hospital admission planning for enrolled consumers.

Responsibility for Hospital Discharge Planning: 5

The ACT model includes the ACT team participating in hospital discharge planning. Although MHS' ACTiOn team is infrequently involved in the decision to hospitalize consumers, the ACTiOn team works closely with Unit 4C and other inpatient units once a consumer is hospitalized and collaborates with inpatient units on all hospital discharge plans. This results in a rating of 5 and was assessed through staff interviews and consumer records.

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 two consumers during the evaluation period, resulting in a rating of 5. This was determined through consumer records and staff interview.

Nature of Services

In Vivo Services: 4

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 (i.e., in vivo), which refers to location where clients live, work, and interact with other people. According to ACT service records, 66% of MHS ACTiOn team encounters with consumers during the evaluation period occurred in community-based settings. As this percentage falls within the range of 60-79%, the rating for this measure is 4. *This represents an increase from 2017's rating of 3, when 59% of MHS ACTiOn team encounters with consumers occurred in the community.*

No Drop Out Policy: 5

This criterion refers to the retention rate of consumers in the ACT program over a 12-month period. According to consumer records and staff report, three consumers dropped out of the program during the evaluation period, resulting in a 6% drop out rate and a rating of 5. Any consumers who moved out of the area or required and enrolled in a higher level of care (e.g., conserved) were removed from analysis for this criterion. *This represents an increase from the 2017 rating of 3, when there was a 22% dropout rate.*

Assertive Engagement Mechanisms: 5

As part of ensuring engagement, the ACT model includes using street outreach and legal mechanisms as indicated and available to the ACT team. During the evaluation period, MHS' ACTiOn team demonstrated well thought-out and consistent use of street outreach and legal mechanisms to engage consumers, including working closely with CCBHS to implement the AOT civil court process for consumers who meet AOT criteria and refuse to accept or participate in ACT voluntarily. It is important to note that the decision to use or commence a civil court process is a collaborative effort between MHS and CCHBS, and the actual implementation of a legal mechanism, (i.e. AOT voluntary settlement agreement or court order) is shared between all AOT partners. The assertive engagement mechanism rating was based upon staff interviews, team meeting observation, and consumer records. *The increased use of the civil court petition for AOT, when appropriate, demonstrates significant improvement in the use of all available legal mechanisms to engage consumers in treatment and is reflected in an increased rating from 2 in 2017 to 5.*

Intensity of Services: 4

Intensity of services is defined by the face-to-face service time MHS' ACTiOn team staff spend with clients. Full fidelity to the ACT model requires that consumers receive an average of two hours per week of face-to-face contact. According to ACT service records, ACT consumers received an average of 1.91 hours of ACT services per week, resulting in a rating of 4. *This represents a decrease from the 2017 rating of 5, when consumers received 2.67 hours of ACT services per week. The decrease in service intensity may reflect reduced staff capacity due to the increased number of active consumers and/or the staff turnover experienced during the last year.*

Frequency of Contact: 3

Fidelity to the ACT model requires that ACT consumers have an average of at least four face-to-face contacts per week. According to ACT service records, ACT consumers received an average of 2.65 face-to-face contacts per week during the evaluation period, resulting in a rating of 3 as it falls within the range of 2-3 face-to-face contacts per week. *This represents a decrease from the 2017 rating of 4, when consumers received an average 3.15 face-to-face contacts per week. The decrease in service frequency may reflect reduced staff capacity due to the increased number of active consumers and/or the staff turnover experienced during the last year.*

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 community integration and functioning. According to staff, consumer, and family member discussions as

well as ACT service records, MHS' ACTiOn team exceeds the expectation of four contacts per month with informal support systems, resulting in a rating of 5.

Individualized Substance Abuse Services: 3

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. Full fidelity to the ACT model requires that consumers with substance use disorders receive an average of at least 24 minutes of formal, individualized substance abuse services per week. MHS' ACTiOn team incorporates principles of dual disorder recovery into treatment and provides informal substance use services through their encounters with ACT consumers. However, based upon interviews with staff, it does not appear that the ACTiOn team is currently providing formal, individualized substance use services, resulting in a rating of 3. *The rating represents a decrease from the 2017 rating of 5. The difference in the level of substance use treatment from may reflect staff changes in the previous year—including the departure of a full-time staff member who provided substance use services—as well the increased number of ACT consumers, approximately two-thirds of whom have co-occurring disorders. Moving forward, the ACTiOn team should explore ways to expand formal, individualized substance use treatment to meet the treatment needs of a growing number of ACT consumers with co-occurring disorders.*

Co-Occurring Treatment Groups: 3

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. Full fidelity to the ACT model requires that 50% or more of consumers with substance use disorders attend at least one substance abuse treatment group per month. The MHS' ACTiOn team provides a weekly co-occurring disorder group led by the dual recovery specialist, family partner, and other clinical staff. Of the 49 active ACT consumers, 34 had documented co-occurring substance use disorders. However, according to ACTiOn team staff, typically only 20% of these consumers participate in the co-occurring disorder group each month, resulting in a rating of 3. *This rating represents a decrease from the 2017 rating of 5. As described previously, the lower rating may reflect the increased number of consumers with co-occurring disorders and/or reduced staff capacity associated with staff turnover. Moving forward, the ACTiOn team should explore ways to engage more consumers in co-occurring treatment groups.*

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, resulting in a rating of 5. This was observed through a review of personnel records, team meeting observation, and staff interviews.

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 in previous years of **professional and caring staff**, **partnership and responsiveness of the staff to consumer and family needs**, **the outreach process**, and an **inclusive approach to services**, program strengths noted are:

- **Trust:** Consumers and family members discussed their trust in the ACTiOn Team, noting that they can talk to staff about anything without judgement. Some consumers shared that although they were initially distrustful of the ACTiOn team and the program, the staff developed consumers' trust by always meeting consumers where they are in their recovery and consistently demonstrating their interest and investment in consumers' lives and recovery.
- **Meaningful Activities:** In response to consumer and family feedback during previous years, the ACTiOn team began implementing a recreation group, which includes weekly bowling trips, hiking, swimming, and other outings. Consumers highlighted these activities as one of their favorite aspects of the program and mentioned that it gives them something to look forward to. Some consumers also shared that the activities and groups help them in their recovery by filling their free time and maintaining a routine schedule, particularly after returning from the hospital or jail.
- **Consumer Outcomes:** As with last year, it is notable that many consumers 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 impressed by consumers who obtained and maintained housing, reduced crisis and hospitalization, decreased or stopped substance use, improved and repaired family relationships, are either working or volunteering, and enrolled in or graduated school since enrolling in the program.

The following areas for program improvement also emerged through discussions with consumers and family members:

- **Family Groups:** Through the assessor's observation of participant focus groups, it became apparent that consumers are all in different stages of recovery and that families need meaningful opportunities to interact with other families and/or their loved ones to share their experiences,

share knowledge and resources, and provide support to maintain hope in their loved ones recovery. MHS' ACTiOn team should consider re-introducing family support and psychoeducation groups as well as multi-family groups with loved ones to provide these opportunities.

- **Reliability:** Although consumers and family members generally shared a high level of satisfaction with MHS' ACTiOn team and services, focus group participants noted some changes in the frequency and/or reliability of scheduled encounters associated with staff changes and turnover. Specifically, focus group participants mentioned a few instances when staff missed or re-scheduled appointments or when their medications were late or running low before being refilled. While no consumer went without medications, they did discuss the anxiety they experienced when their medication supply ran low and they were unsure when the refill would be delivered. Consumers also discussed the departure of the dedicated vocational specialist and missed having more formal vocational support. It is important to note that at the time of the fidelity assessment, MHS had recently hired a staff member with vocational rehabilitation training and has also since filled a number of vacant positions to stabilize staffing.

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 adequately staffed with team members with diverse skill sets and who are 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 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, consumers and family members shared accounts of increasing stability, as well as a number of tangible successes and accomplishments.

The program also substantially improved fidelity to the ACT model on a number of measures, including explicit admission criteria, use of assertive engagement mechanisms, and a no drop out policy. Over the course of the last year, it appears that MHS' ACTiOn team considerably strengthened communication and collaboration with CCBHS contributing to 1) improved shared decision-making about consumers accepted into the ACT program, and 2) consistent and appropriate use of the civil court petition for AOT to compel service engagement among consumers who meet AOT criteria and refuse to accept or engage in treatment voluntarily. The program enrolled and retained a higher number of consumers than in previous years. At the time of the 2018 assessment, the program had 49 active consumers, compared to 32 in 2017. Moreover, only two consumers were discharged from the program in the 12 months prior to the 2018 fidelity assessment, compared to nine consumers in year prior to the 2017 assessment.

Opportunities

While the fidelity assessment revealed a high degree of alignment with the ACT model, there are opportunities for improvement. During the year prior to the assessment, MHS' ACTiOn team experienced significant staff turnover and transitions, particularly among program leadership. The staff changes along with the increased number of active consumers likely contributed to reduced staff capacity and decreases in the intensity and frequency of services during the evaluation period. While MHS is taking steps to stabilize staffing and has already filled several vacant positions, MHS may wish to explore the following areas to identify how to best scale the program to continue and strengthen fidelity to the ACT model:

- **Staffing and Program Capacity:** MHS' ACTiOn Team is adequately staffed for the current caseload of 49. However, at the time of the fidelity assessment, there were a number of consumers who were active in the outreach and engagement phase or the AOT petition process. As the program approaches the contracted number of 75 consumers, there would be gaps in a number of ACT team positions with the current staffing. Specifically, there would be a need to increase psychiatry, nursing, substance use treatment, and vocational rehabilitation to ensure alignment with the ACT model. Additionally, as mentioned, there was a higher rate of turnover than expected. MHS may wish to explore how to increase staff retention and ensure staff capacity meets growing needs.
- **Substance Abuse Services.** Some of the lowest scores from this assessment include individualized substance use services and co-occurring treatment groups. Although the ratings may be attributable in part to staff changes and the increased numbers of consumers with co-occurring disorders, MHS should explore ways to formalize and expand substance use treatment. One approach may be to implement a weekly co-occurring treatment group in each of the three regions in Contra Costa County, rather than just one group at the ACTiOn team's main office. This will allow more opportunities for a greater number consumers to participate in treatment.

Additionally, MHS may wish to consider re-introducing structured opportunities for family participation, as discussed above, such as a family support or psychoeducation group as well as a multi-family group.

Conclusion

MHS' ACTiOn Team received an average fidelity rating of 4.50 and scored in the "high fidelity" range. The assessors were impressed with the staff; program implementation improvements over the past year; 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 staff turnover and capacity, expanded substance use treatment, and family support. 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
HEALTH SERVICES

CONTRA COSTA COUNTY ASSISTED OUTPATIENT TREATMENT

CUMULATIVE EVALUATION REPORT FINDINGS

October 2018

Resource Development Associates

RDA™

Introduction

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AOT Timeline

February 5, 2015

- Contra Costa Board of Supervisors authorized Assisted Outpatient Treatment.

February 1, 2016

- CCBHS began accepting AOT referrals.
- CCBHS received its first referral and conducted its first investigation.

February 5, 2016

- MHS outreaches to the first eligible individual.

March 4, 2016

- MHS enrolls the first ACT consumer.

June 30, 2018

- Since AOT implementation, CCBHS has received 475 referrals and MHS has enrolled 70 consumers

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Research Questions & Evaluation Period

Evaluation Period: February 2016 – June 2018

Question 1	Question 2	Question 3
• What are the outcomes for people who participate in ACT and AOT, including the DHCS required outcomes? How faithful are ACT services to the ACT model?	• What are the differences in demographics, service patterns, and outcomes between those who agree to participate in ACT services voluntarily and those who participate with an AOT court order or voluntary settlement agreement?	• What are the differences in demographics, service utilization, and outcomes between those who engage in existing FSP services and those who receive ACT services?

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Data and Limitations

Data Provided

- CCBHS
  - Referral and investigation information
  - Service utilization data for all specialty mental health services provided or paid for by CCBHS
- MHS
  - Outreach and engagement contacts
  - Clinical assessments/outcomes
  - FSP assessments (PAF and KET)
  - ACT consumer and family focus groups (from previous ACT fidelity assessment)
- Sheriff's Office
  - Bookings and booking reasons
- Cost Data from CCBHS, County Counsel, MHS, Public Defender's Office, and Superior Court

Limitations

- Only 16 consumers have participated in AOT Treatment with court involvement
  - RDA aggregated some outcomes to maintain confidentiality
  - Proportions, averages, and rates shift dramatically based on experiences of relatively few individuals
- Time period prior to enrollment longer than during/after enrollment
  - RDA standardized outcome measures to rates per 180 days to account for variability in enrollment lengths and available pre- and post-data

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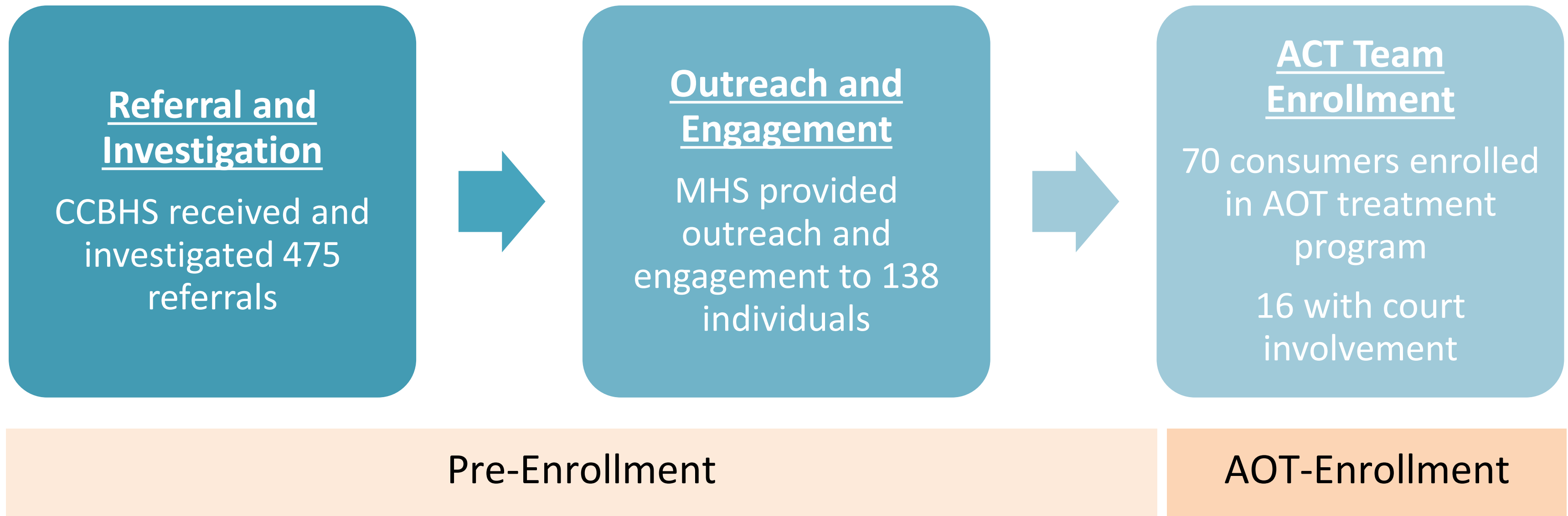
Findings: Research Question 1

- What are the outcomes for people who participate in ACT and AOT, including the DHCS required outcomes?
- How faithful are ACT services to the ACT model?

Pre- and AOT-Enrollment



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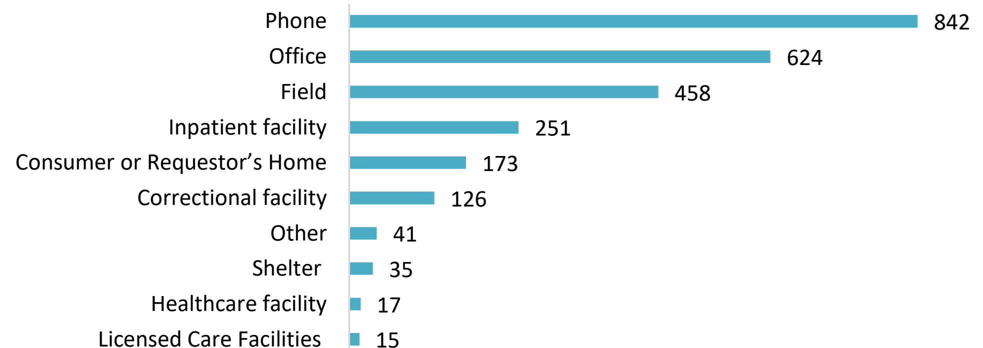
Referrals and Investigations

CCBHS received referrals from a diversity of qualified requestors, including family members, mental health providers, and law enforcement officials.

Requestor	Percent of Total Referrals (N = 475)
Parent, Spouse, Adult Sibling, or Adult Child	60% (n = 286)
Treating or supervising mental health provider	20% (n = 95)
Probation, parole, or peace officer	13% (n = 63)
Not a qualified requestor or "other"	4% (n = 20)
Director of Hospital where individual is hospitalized	<3%
Adult who lives with individual	<3%

Nearly every referred individual who was eligible for AOT and/or was able to be located was connected to mental health services.

Investigation Outcome	Percent of Referrals (N = 475)
Referred to MHS	32% (n = 154)
Engaged or Re-Engaged with a Provider	14% (n = 66)
Ongoing Investigation	17% (n = 81)
Investigated and Closed	37% (n = 174)



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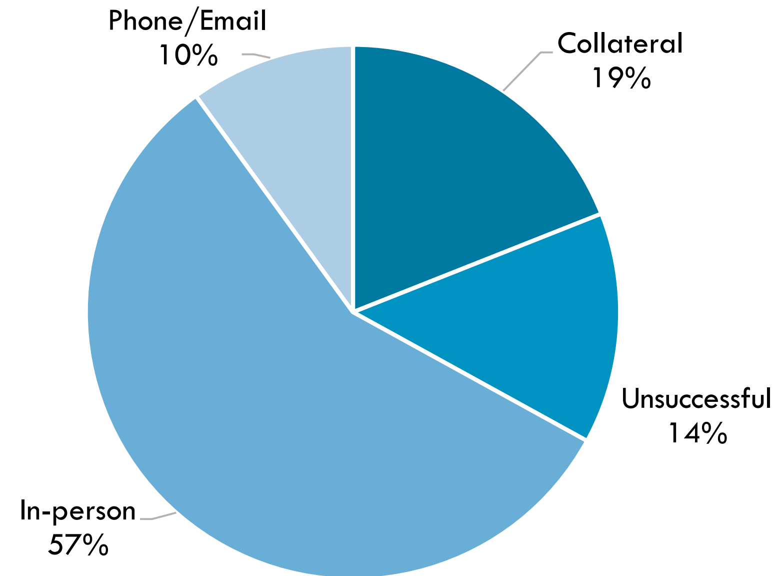
Outreach & Engagement

MHS has enrolled half of all AOT referred individuals to ACT through their ongoing outreach and engagement efforts.

Outreach and Engagement Outcome	Percent of Consumers	Number of Consumers
Enrolled in ACT Services	51%	70 total *54 voluntarily* *16 with court involvement*
Still Receiving Outreach and Engagement Services	12%	17
Not enrolled in ACT	37%	51

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



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Consumer Profile

Category	ACT Consumers (n=70)
Gender	
Male	56% (n = 39)
Female	44% (n = 31)
Race and Ethnicity	
Black or African American	19% (n = 13)
Hispanic	16% (n = 11)
White	56% (n = 39)
Other or Unknown	9% (n = 7)
Age at Enrollment	
18 – 25	21% (n = 15)
26+	79% (n = 55)

- **The majority of ACT consumers (64%, n = 45) have a primary diagnosis of a psychotic disorder, and 71% (n = 50) had a co-occurring substance use disorder at the time of enrollment.**
- Of the ACT consumers for whom there was data (n = 63):
  - **71% had a GED or higher education level** at the time of enrollment
  - **59% were unemployed** in the12 months prior to enrolling in ACT.
  - **49% received supplemental security income** in the 12 months prior to enrolling in ACT.

ACT Fidelity

Domain	Criterion	2017 Rating	2018 Rating
Human Resources: Structure and Composition	Small caseload	5	5
	Team approach	4	5
	Program meeting	5	5
	Practicing ACT leader	4	5
	Continuity of staffing	3	4
	Staff capacity	4	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**	**2**	**5**
	Intake rate	5	5
	Full responsibility for treatment services	5	5
	Responsibility for crisis services	5	5
	Responsibility for hospital admissions	**5**	**1**
	Responsibility for hospital discharge planning	5	5
	Time-unlimited services	5	5

Domain	Criterion	2017 Rating	2018 Rating
Nature of Services	In vivo services	3	4
	No drop-out policy	3	5
	Assertive engagement mechanisms	**2**	**5**
	Intensity of services	5	4
	Frequency of contact	4	3
	Work with support system	5	5
	Individualized substance abuse treatment	**5**	**3**
	Co-occurring disorder treatment groups	**5**	**3**
	Co-occurring disorders model	5	5
	Role of consumers on treatment team	5	5

Overall	2017	2018
ACT Fidelity Score	***4.42***	***4.50***

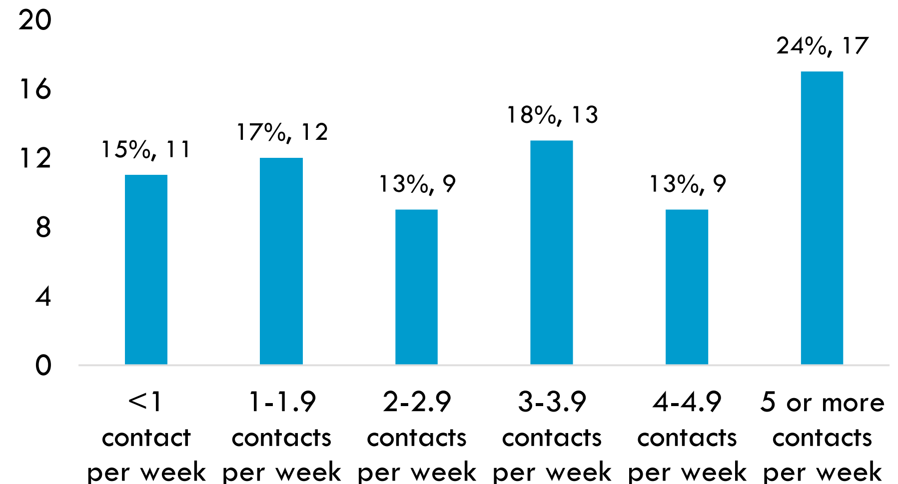
ACT Service Participation (N = 62)*

ACT Services

- Avg. length of enrollment: 354 days
- Avg. number of face-to-face encounters: 4 per week
- Avg. hours of face to face encounters: 4 per week

ACT Treatment Adherence

- **Overall, 66% of ACT consumers were adherent to treatment.** In FY 16/17, 93% of consumers were adherent.



Crisis Episodes and Psychiatric Hospitalizations

The majority of consumers experienced fewer psychiatric hospitalizations and crisis episodes during ACT.

	Crisis Episodes Before ACT Enrollment	Crisis Episodes During ACT Enrollment
Number of Consumers	91%, n = 61	52%, n = 35
Average Number of Crisis Episodes	3.1 episodes per 180 days	2.2 episodes per 180 days
Average Length of Stay	1.4 days	1.2 days

	Psychiatric Hospitalizations Before ACT Enrollment	Psychiatric Hospitalizations During ACT Enrollment
Number of Consumers	55%, n = 37	31%, n = 21
Average Number of Hospitalizations	1.0 episodes per 180 days	0.7 episodes per 180 days
Average Length of Stay	7.3 days*	10.0 days**

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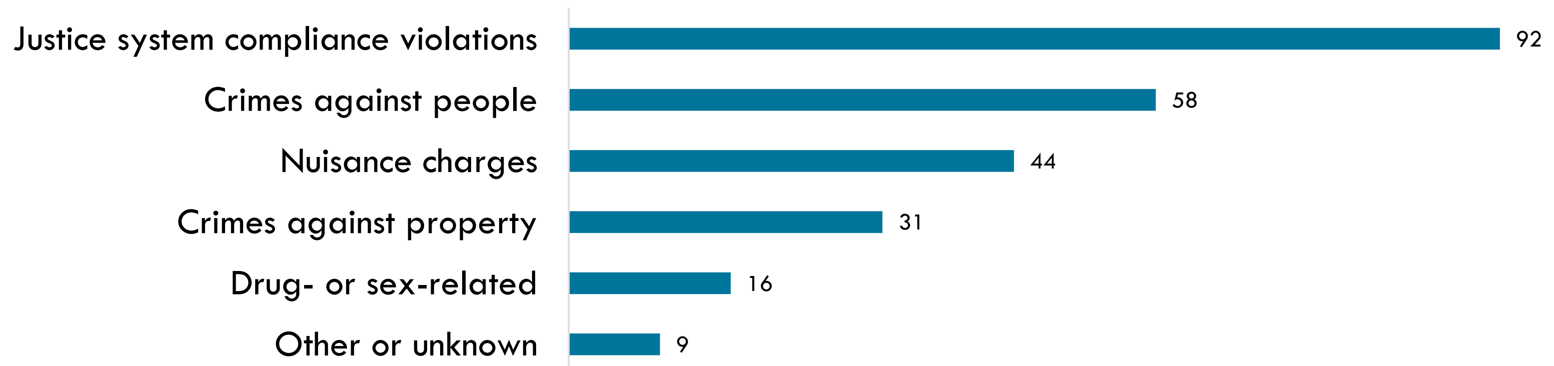
Criminal Justice Outcomes

Significantly fewer ACT consumers were arrested and booked during ACT enrollment

	Jail Bookings Before ACT Enrollment	Jail Bookings During ACT Enrollment
Number of Consumers	67%, n = 45	31%, n = 21
Average Number of Crisis Episodes	2.3 episodes per 180 days	2.4 episodes per 180 days
Average Length of Stay	29 days	18.5 days

Types of Charges during ACT Enrollment



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Housing Status

The majority of consumers (62%, n = 33) either obtained or maintained housing while in ACT.

Consumers who obtained housing	Consumers who maintained housing	Consumers who were not stably housed
• **13%** of consumers were not housed before ACT but obtained housing while enrolled	• **49%** of consumers were housed before ACT and continued to maintain housing while enrolled	• **9%** of consumers were housed before ACT but did not maintain housing during ACT • **28%** of consumers were not housed before or during ACT enrollment

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AOT Costs

FY 17/18 AOT Budget and Actual Expenses

Partner	FY 17/18 Budget	FY 17/18 Actual Costs
MHS	$2,014,000	$1,560,080
CCBHS	$350,000	$252,839
County Counsel	$157,000	$32,379
Public Defender	$133,500	$56,250
Superior Court	$128,000	$2,585
Total	**$2,782,500**	**$1,904,133**

County anticipated 70% of all services provided would be billable and 35% of the revenue would therefore come from Medi-Cal FFP. Total billing for FY17/18 was $383,163 (25% of actual expenses), which is below what was anticipated.

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AOT Cost Savings

Pre- and Post-Enrollment Cost Comparison

	Pre-Enrollment	Post-Enrollment	Total Difference	Annual Estimate
Outpatient and Residential Mental Health Services	$5,280,971	$3,868,976	$1,411,995	$584,274
Psychiatric Hospitalization	$2,167,051	$1,049,866	$1,117,185	$462,283
Jail Bed Days	$507,722	$194,192	$313,530	$129,737
Total Mental Health Services	$7,448,022	$4,918,842	$2,529,180	$1,046,557
Total Mental Health and Jail	$7,955,744	$5,113,034	$2,842,710	$1,176,294

AOT reduced the overall cost of care for the 70 enrolled individuals by $2,842,710. Of this amount, AOT produced a hard cost savings of $1,117,185 over the first 29 months of implementation. Accounting for FY 17/18 operations costs, AOT produced $371,069 in hard costs savings.

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Findings: Research Question 2

- What are the differences in demographics, service patterns, and outcomes between those who agree to participate in ACT services voluntarily and those who participate with an AOT court order or voluntary settlement agreement?

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Consumer Profile and Pre-Enrollment Outcomes

Among the 70 consumers who enrolled in AOT since program implementation, 16 enrolled with court involvement.

There are few differences in the demographics or diagnoses between individuals enrolled in ACT voluntarily and through the court.

While consumers in both groups received comparable amounts of outreach and engagement from MHS, it took more time for the Care Team to enroll court-involved individuals.

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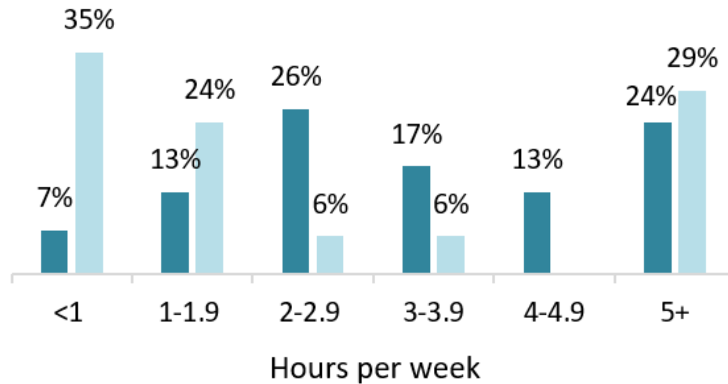
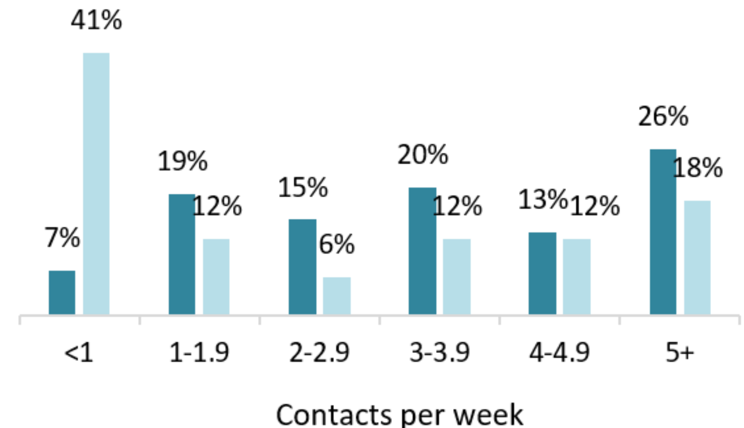
Service Utilization

A larger proportion of court-involved consumers have lower service participation compared to voluntarily enrolled consumers.

Intensity of ACT Contacts per Week



Frequency of ACT Contacts per Week



Voluntary Court-Involved

Crisis Episodes and Psychiatric Hospitalizations

Individuals who enrolled voluntarily saw a substantial decrease in crisis episodes and inpatient hospitalizations during ACT.

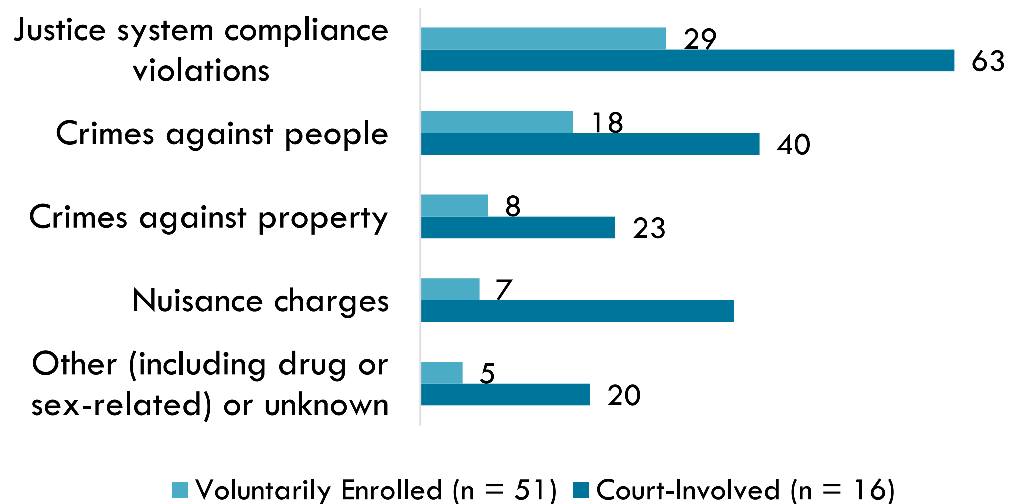
		Before ACT Enrollment		*During ACT Enrollment*	
		Crisis	***Hospitalization***	***Crisis***	***Hospitalization***
Voluntarily Enrolled ACT Consumers (n = 51)	Number of Consumers	90%, n = 46	53%, n = 27	47%, n = 24	24%, n = 12
	Average Number of Episodes	3.2 episodes per 180 days	1.1 episodes per 180 days	2.1 episodes per 180 days	0.8 episodes per 180 days
	Average Length of Stay	1.5 days	13.3 days	1.2 days	25.8 days
Court-Involved ACT Consumers (n = 16)	Number of Consumers	94%, n = 15	63%, n = 10	69%, n = 11	56%, n = 9
	Average Number of Episodes	2.9 episodes per 180 days	0.9 episodes per 180 days	2.7 episodes per 180 days	0.8 episodes per 180 days
	Average Length of Stay	1.3 days	8.1 days	1.2 days	21.3 days

Criminal Justice Outcomes

Individuals who enrolled voluntarily saw a substantial decrease in jail bookings during ACT.

		Before ACT enrollment	During ACT enrollment
Voluntarily Enrolled (n = 51)	Number and % of Consumers w/ Jail Bookings	61%, n = 31 (1.7 bookings per 180 days)	20%, n = 10 (.7 bookings per 180 days)
Court Enrolled (n = 16)	Number of % Consumers w/ Jail Bookings	88%, n = 14 (3.6 bookings per 180 days)	69%, n = 11 (3.9 bookings per 180 days)

A greater proportion of court-involved consumers were booked into county jail before and after AOT enrollment, and charged with more criminal offense and justice system compliance violations.



Housing Outcomes

A larger proportion of voluntarily enrolled consumers were stably housed compared to court-involved consumers.

Findings: Research Question 3

- What are the differences in demographics, service utilization, and outcomes between those who engage in existing FSP services and those who receive ACT services?

ACT and FSP Consumer Profiles

	ACT Consumers (N =70)	FSP Consumers (N = 163)
Gender		
Male	56% (n = 39)	57% (n = 93)
Female	44% (n = 31)	43% (n = 70)
Race and Ethnicity		
Black or African American	19% (n = 13)	35% (n = 57)
Hispanic	16% (n = 11)	19% (n = 31)
White	56% (n = 39)	31% (n = 51)
Other or Unknown	9% (n = 7)	15% (n = 24)
Age at Enrollment		
18 – 25	21% (n = 15)	31% (n = 51)
26 +	79% (n = 55)	69% (n = 112)

- ***There are greater proportion of White consumers and smaller proportion of Black and Latino consumers enrolled in ACT compared to FSP.***
- ***ACT consumers were more likely to be diagnosed with a disorder that included psychosis (92% of ACT consumers vs. 62% of FSP consumers) and less likely to be diagnosed with unipolar depression.***

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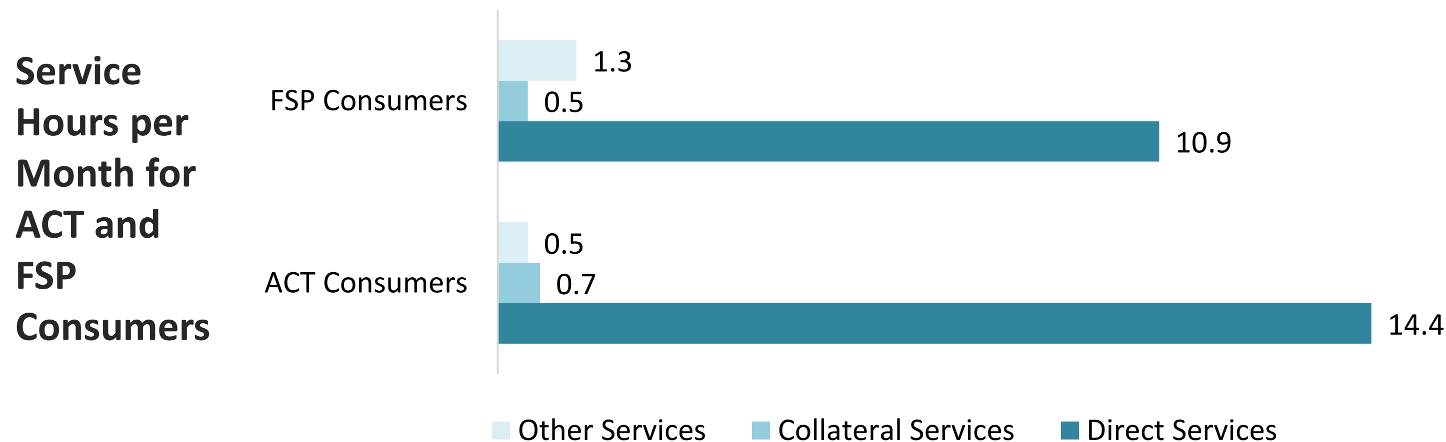
ACT and FSP Service Utilization

ACT consumers engaged in services more often, for longer durations, than FSP consumers.

	ACT Consumers (N = 71)		FSP Consumers (N = 167)	
	Average	*Range*	*Average*	*Range*
Length of Enrollment	354 days	33-830 days	400 days	38 – 880 days
Frequency of Service Encounters	3.8 face to face contacts per week	<1 – 13 face-to-face contacts per week	1.8 face-to-face contacts per week	<1 – 8 face-to-face contacts per week
Intensity of Services	3.6 hours of face-to-face contact per week	<1 – 12 hours of face-to-face contact per week	2.8 hours of face-to-face contact per week	<1 – 13 hours of face-to-face contact per week



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ACT and FSP Consumer Crisis Episodes and Psychiatric Hospitalizations

	ACT Consumers (N = 67)			
	Before ACT Enrollment		***During ACT Enrollment***	
	Crisis	*Hospitalization*	*Crisis*	*Hospitalization*
Number of Consumers	91%, n = 61	55%, n = 37	52%, n = 35	31%, n = 21
Average Number of Episodes	3.1 episodes per 180 days	1.0 episodes per 180 days	2.2 episodes per 180 days	0.7 episodes per 180 days
Average Length of Stay	1.4 days	7.6 days	1.2 days	10.0 days**
	FSP Consumers (N = 163)			
	Before FSP Enrollment		***During FSP Enrollment***	
	Crisis	*Hospitalization*	*Crisis*	*Hospitalization*
Number of Consumers	75%, n = 122	42%, n = 68	43%, n = 70	19%, n = 31
Average Number of Episodes	1.5 episodes per 180 days	0.6 episodes per 180 days	2.3 episodes per 180 days	0.9 episodes per 180 days
Average Length of Stay	1.2 days	8.5 days*	1.2 days	8.1 days**

**Average is 12 days if 2 long term hospitalizations of over 100 days are retained;*
*** Average is 24 days if 2 long term hospitalizations of over 100 days are retained*

Employment Outcomes

Between enrollment and July/August 2018 there is a 16% increase in ACT consumers with employment and 14% decrease in FSP consumers with employment.

Employment Measures	AOT Clients (MHS' ACT program)	FSP Clients
Employed at some point in 12 months prior to program enrollment (% Y/N)	<10%	18%
Length of employment in 12 months prior to program enrollment (# of weeks)	26.0 weeks	18.7 weeks
Average amount of employment in 12 months prior to program enrollment (hours/week)	24.3 hours/week	22.4 hours/week
Employed at some point in 30 days prior to program enrollment (% Y/N)	<10%	18%
Employed at some point during July/August 2018 (% Y/N)	21%	7%
Average amount of employment in 30 days prior to program enrollment (hours/week)	16.5 hours/week	20.0 hours/week
Average amount of employment in July/August 2018 (hours/week)	25.0 hours/week	17.2 hours/week

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Questions and Answers

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