



ALCOHOL, DRUG & MENTAL HEALTH SERVICES

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To: Supervisor Wilma Chan and Supervisor Keith Carson

From: Alex Briscoe, Agency Director, Health Care Services Agency
Toni Tullys, Deputy Director, Behavioral Health Care Services
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Date: May 1, 2013

RE: Board of Supervisor Recommendations for AB 1421

As requested at the March 18, 2013 Board of Supervisors Public Hearing on Laura's Law, HCSA/BHCS has developed a set of recommendations focused on voluntary and assisted outpatient treatment to meet the needs of mental health clients/consumers with history of non-compliance with treatment, or those seriously mentally ill clients who our system has been unable to reach and engage in ongoing treatment.

Over the past 45 days, BHCS has worked closely with our existing provider and stakeholder groups including multiple consumer and families groups, the Mental Health Board, acute care clinical providers and our Criminal Justice Mental Health program. We have had lengthy conversations with additional system partners including Patient Rights Advocates and the Social Services Agency Public Guardian/LPS Conservator. We have carefully and aggressively sought input from other jurisdictions that have wrestled with this issue.

Specifically, we have reviewed 1421 and other AOT initiatives at our monthly Greater Bay Area Mental Health Directors meeting, learning from our colleagues what they have put in place, what has worked well and what has not. Throughout these conversations, we have identified gaps in our system, clearly defined our needs, and considered many different service strategies.

To thoroughly understand the 1421 programs that are in place we worked directly with Michael Heggarty, Nevada County's Mental Health Director, about their 1421 program, which is the only fully implemented program in California. We have researched the details of voluntary AOT programs in Los Angeles, San Diego and San Francisco Counties. We are not recommending adoption of 1421 in Alameda County, but we were impressed with San Diego's new In Home Outreach Team, that we have included it in our recommendations as a program we believe should be implemented in Alameda County. We also include in our recommendations ongoing

analysis and research on other AOT models and expanded use of the LPS Conservatorship program.

The BHCS recommendations focus on responding to the needs of clients/consumers that are not engaged in services or are resistant to treatment and their family members. This includes individuals that “fall through the cracks” of the system and may be in and out of psychiatric emergency rooms or on and off 5150’s. The needs of these clients/consumers are the same as those identified in the AB1421 legislation.

We recognize that sometimes people are not ready for treatment, and as a result, may need repeated attempts for engagement and treatment. We also recognize that families experience significant frustration and disappointment at not being able to help their loved ones navigate the mental health system and get the help they need. We believe that our recommendations will benefit clients/consumers and families and fill the gaps identified in our system.

There are seven recommendations in the following memorandum, after your review and feedback, we would request an opportunity to present them to Health Committee with specific operational and implementation plans. Our goal is to seek BOS approval for the implementation plan by the end of the fiscal year (June 2013).

Summary of Recommendations

Consistent needs emerged in AB1421 discussions with clients/consumers, families, providers and county partners. The following summarizes the goals of the seven specific recommendations to follow:

- Implement new intensive case management for clients/consumers as soon as they are discharged from the emergency room, acute hospital or sub acute facilities to help them transition back into the community and to better support therapeutic gains made after acute episodes.
- Identify and deploy strategies to engage clients/consumers who are not compliant or engaged in services and/or treatment and provide ongoing support until they are engaged and have a source for care.
- Implement new outreach and engagement initiatives targeted to meet the needs of youth, adult consumers and family members.
- Address the special needs of families for support, information and assistance.
- Provide services to individuals experiencing either their first hospitalization or their first incarceration due to mental illness.

The seven recommendations to follow will:

- Offer an array of services that make it possible for clients/consumers to engage, whatever their level of readiness;
- Increase resources for clients/consumers and families, with an emphasis on youth, individuals recently diagnosed with a mental illness and those that may “fall through the cracks”;
- Increase choices for individuals to engage in services and treatment and
- Utilize evidence-based practices that demonstrate improved client outcomes.

Outreach and engagement are critical components of this effort, since our goal is to connect with individuals that have mental illness and are not involved in services. Outreach will be delivered differently to clients/consumers, depending on their level of engagement and trust. Youth outreach will be delivered at venues where youth gather. Adult consumer outreach may occur at their homes, in the community or during an acute hospital stay or in a longer term, sub acute facility stay. Family members will be able to receive support and assistance in their homes, in the community or within a hospital or service setting.

The Recommendations:

1. Expand the STEPS Intensive Case Management Program and broaden the eligibility criteria to meet the needs of a broader target population.
2. Replicate San Diego County’s In Home Outreach Team (IHOT)
3. Pilot a Street Outreach Program to meet and engage young people “where they’re at” in the community and help link them to services and treatment.
4. Develop a Psycho-education Multifamily Group to support family members of youth who are not engaged in or compliant with their treatment.
5. Analyze voluntary AOT programs in other jurisdictions to learn about their program design, partners and client/consumer outcomes and to assess their fit for Alameda County.
6. Collaborate with the Social Services Agency Public Guardian/LPS Conservator’s office to pilot expanded use of the LPS Conservatorship.
7. Hire an Acute Care Clinical Manager to work at John George Psychiatric Pavilion and identify BHCS services and community resources for clients/consumers at the hospital.

Program Recommendations and Descriptions

1. Expand the Steps Towards Empowerment, Progress and Success (STEPS) Program

BHCS Recommendation: Expand the STEPS program eligibility criteria and increase program capacity to provide intensive case management to a broader target population.

Since this is an existing program, which will be providing the same type of care to a larger client/consumer population, BHCS can allocate additional Mental Health Services Act (MHSA) funding to support the expansion.

Desired Outcomes: Reduce client/consumer utilization of emergency rooms, psychiatric emergency rooms and incarceration facilities; engage clients/consumers in care planning and community-based services; transition clients/consumers successfully from acute care settings into the community and improve client/consumer quality of life.

Program Description:

Current STEPS Client Eligibility Criteria:

- 18 years of age or older
- Authorized by BHCS based on a BHCS assessment, prioritization and referral
- Achieved significant stability at local Mental Health Rehabilitation Centers or Skilled Nursing facilities
- Require short term, 60-90 day Intensive Case Management, and are likely to require assistance in obtaining and maintaining appointments, housing and medication regimes
- Have a primary psychiatric diagnosis on Axis 1 and have been ill for at least two years
- Provide voluntary consent to receive services

Expanded STEPS Client Eligibility Criteria will include the following (which incorporates elements of the Laura's Law criteria):

- Person with first hospitalization for mental illness or first incarceration with a mental illness
- Person with serious mental illness that has been in an acute hospital or in a subacute facility and would benefit from 60-90 day Intensive Case Management upon discharge to the community

- Person demonstrates lack of compliance in treatment and one of the following:
 - At least twice in last 36 months hospitalized or incarcerated
 - Serious attempt or actual violent behavior to self or others in last 48 months
- Person is likely to benefit from treatment
- By history or current situation, person is likely to end up in involuntary treatment if they do not receive services
- This program will be least restrictive treatment

The STEPS program provides community-based Intensive Case Management (ICM) services and crisis intervention to clients in the first 60-90 day period following their discharge from mental health rehabilitation centers and skilled nursing facilities. With the expanded eligibility criteria, these services will also be provided to clients/consumers experiencing their first hospitalization or incarceration due to mental illness, as well as clients that have been previously hospitalized and have not been compliant with their treatment. The ICM model includes an average of two client visits per week, but often includes daily visits and daily staff meetings to discuss client care plans. Clients are discharged from the program when they have met their care plan and/or transitional goals, obtained significant stabilization within 60 to 90 days of service or required a higher level of care to meet their current needs.

2. Replicate San Diego County’s In Home Outreach Team to Support Clients and Families

BHCS Recommendation: Implement a pilot In Home Outreach Team (IHOT) to provide mobile outreach to adults with serious mental illness and to family members who are dealing with the mental illness of loved ones.

BHCS strongly recommends this new program, as it is designed to meet people in their homes, and in the community, and to provide immediate support and assistance. BHCS has reviewed background materials and discussed the IHOT Program in detail with the program developers, as well as the staff working directly with clients and family members.

BHCS could fund this program through the MHSA.

Program Description: IHOT uses mobile teams to provide outreach to adults with serious mental illness who are reluctant or “resistant” to receiving mental health services. IHOT also provides extensive support and education to family members who are dealing with the mental illness of a loved one. IHOT combines the services of a family partner, peer/consumer specialist and a mental health professional to work with those that are difficult to engage and resistant to treatment. This is an outreach and engagement program, rather than a service program, and the

team is trained on how to effectively reach out and support individuals in need.

The program's goals are to:

- Connect participants and family members with education, support and community resources
- Connect participants with appropriate medical and mental health care as is feasible
- Collaborate with participants and their families to help them fulfill their hopes and dreams and go on to lead meaningful lives

Eligibility Criteria:

- 18 years or older
- Presence of serious mental illness with functional impairment
- Not currently enrolled in mental health treatment and resistant to mental health treatment

The IHOT program was developed by Telecare, Inc. for San Diego County, as a voluntary alternative to Laura's Law. Between January 1, 2012 and September 30, 2012, 295 persons have been referred to IHOT from across San Diego County. 127 (43%) individuals were determined to be eligible and accepted into the IHOT Outreach Phase. During this phase, staff connects with and supports the family of the participant and attempts to develop a relationship with the potential IHOT participant.

Of those individuals who entered the Outreach Phase, 57 (45%) have already transitioned into the Engaged Phase, which begins when the intended recipient of IHOT services agrees to have an ongoing relationship with the IHOT staff. During this phase, the IHOT team continues to provide support services to the family members. Of note, approximately 75% of these participants are between the ages of 25-59 and 13% were between the ages of 18-24. Schizophrenia/Schizoaffective Disorder represented the most common diagnostic impression (57%) followed by Bipolar Disorder (16%).

Family members made 50% of the referrals, followed by APS (14%) and Psychiatric Emergency Services (10%). IHOT staff had an extensive amount of contact with both family members and the persons accepted into the IHOT program (2,669 contacts during the evaluation period). The vast majority of service contacts were related to Outreach (45% with family and 12% with participants) and Engagement (35% of contacts). During the Outreach Phase, 61% of contacts were with family and 33% were with intended participants. During the Engaged Phase, the emphasis switched as participants received the majority of service contacts. When needed, IHOT staff also helped managed crisis situations and facilitated linkages to resources.

3. Pilot a Street Outreach Team for Youth with Mental Illness

ACBHCS Recommendation: Pilot a Street Outreach Team for Youth (ages 18-24) with a mental illness who are homeless or living on the street and are not engaged in mental health services or treatment.

The BHCS Transition Age Youth (TAY) System of Care will manage the team, which will be staffed by TAY with lived experience as mental health clients. These TAY street workers will engage with the street youth, share their lived experience and personal understanding of “what works”, establish trust, and connect the youth, when they are ready, to an Assertive Community Treatment (ACT) Team for services.

BHCS plans to develop and implement a pilot in the Oakland/Berkeley area and support this effort through MHSI Innovations funding.

Desired Outcomes: Engage with the targeted youth, establish trust and create successful linkages to ACBHCS services.

Program Description: Since 1996, the federal Health and Human Services Agency’s Administration for Children and Families, Family and Youth Services Bureau (FYSB) has provided funding for Street Outreach Programs. These programs serve and protect runaway and homeless youth and youth on the streets who have been, or are at risk of being sexually exploited. Street Outreach Programs have been implemented across the country and include outreach to homeless youth with mental illness.

The Street Outreach Program model is premised on the belief that youth can make positive changes in their lives if presented with reasonable alternatives to street life. Services are offered on the youth’s home turf in a manner that encourages trust and acceptance and is delivered by staff who can relate to youth in a culturally and age-appropriate way. Meeting youth “where they’re at” means more than meeting them “on their turf”. Street outreach workers engage youth, build trust, empower them to make their own choices, and when the youth are ready, help them explore available options and link them to services. If a young person is not ready to engage or consider services, street outreach workers remain available to them until they are.

Street outreach services may include the following:

- Street-based education and outreach
- Individual assessments
- Prevention and education activities
- Information and referrals
- Follow-up support

Outreach workers in a particular city or area know the best places to find young people on the streets. They often find youth in social spaces, such as coffee shops or 24 hour restaurants, in the parts of town where services for homeless people cluster, at places that serve free meals, or in public parks.

Street Outreach Programs include the Janus Youth Program in Portland, Oregon and the Children's Village in Valhalla, New York. For additional information:

<http://www.acf.hhs.gov/programs/fysb/resource/sop-fact-sheet>

4. Develop a Psychoeducational Multifamily Group to Support Families

ACBHCS Recommendation: Develop a Psychoeducational Multifamily (PMF) Group for family members that are affected by young people (Transition Age Youth, ages 18-24) that have a mental illness, may have an alcohol and/or drug issue, and are not connected to services or treatment.

BHCS intends to develop this specific PMF Group and support its implementation through MHSA funding. BHCS currently offers a PMF Group within the Prevention and Recovery in Early Psychosis (PREP) Program in the Transition Age Youth System of Care.

Desired Outcomes: Increased social support for family members; decreased stress for family members; improved family relationships; improved problem solving and coping skills for families and clients and improved mental health status and recovery for clients.

Program Description: William McFarlane, MD, Chief of Maine Medical Center's Department of Psychiatry, developed the Multifamily Group Therapy model, an intervention for treating persons with severe mental illness and their families that integrates psychoeducation and behavioral family therapy in a multiple-family group format. Recognized today as an evidence-based practice by the federal Substance Use and Mental Health Services Administration, these multifamily groups have served tens of thousands of consumers and families across the country. The American Psychological Association also recommends this approach as a best practice for serious mental illness.

The intervention focuses on informing families and support people about mental illness, developing coping skills, solving problems, creating social supports, and developing an alliance between consumers, practitioners, and their families or other support people. Psychoeducation acknowledges the essentially chronic nature of mental illness and seeks to engage families in the rehabilitation process by creating a long-term working partnership and providing them with the information they need.

Practitioners invite five to six consumers and their families to participate in a psychoeducation group that typically meets every other week for at least 6 months. "Family" is defined as anyone committed to the care and support of the person with mental illness. Consumers often ask a close friend or neighbor to be their support person in the group. Group meetings are structured to help people develop the skills needed to handle problems posed by mental illness.

For additional information: <http://www.nrepp.samhsa.gov/viewintervention.aspx?id=120>

5. Analyze voluntary AOT programs in other jurisdictions to learn about their design, partners and client/consumer outcomes and to assess their fit for Alameda County.

On May 15, 2013, Dr. Aaron Chapman, the Interim Director, and I will make a preliminary visit to San Francisco's Lanterman Petris Short Act Community Independence Pilot Project (LPS-CIPP). This program is designed to assist persons who meet LPS criteria to live in the community in the least restrictive setting, to provide community outreach and resources, and to assist individuals to maintain independence and stability. The project is a collaboration among the Office of Conservatorship Services, Community Behavioral Health Services, the Department of Public Health, the Offices of the Public Defender and the District Attorney, physicians and psychologists, community mental health providers and the San Francisco Superior Court.

The LPS-CIPP provides conservatorship, medication and case management to clients/consumers who have a history of psychiatric hospitalizations and non-compliance with treatment, and who are at risk of re-hospitalization or admittance to a longer-term locked psychiatric facility without proper care. The goal of the LPS-CIPP is to provide sufficient supports to these clients such that they can live independently and maintain stability. The program is voluntary and participation requirements are explained to the individual client by the treatment provider and their appointed counsel.

6. Collaborate with the County's Social Services Agency Public Guardian/LPS Conservator

BHCS is exploring conservatorship options with the County's Social Services Agency Public Guardian/LPS Conservator's Office, based on our research of other county approaches and programs. ACBHCS will work closely with the Public Guardian/LPS Conservator as we identify programs to review and consider. In addition, BHCS will collaborate with the Public Guardian/LPS Conservator's Office to provide training opportunities about private conservatorships for interested family and community members.

7. Recruit an Acute Care Clinical Manager to work at John George Psychiatric Pavilion

BHCS is planning to recruit an Acute Care Clinical Manager, who will work at John George Psychiatric Pavilion (JGPP) and identify BHCS services and community resources for

clients/consumers at the hospital. This position will partner with the JGPP staff, connect clients/consumers with BHCS programs and community resources, collaborate with the Family Advocate stationed at JGPP, participate in discharge planning and serve as a clinical liaison between BHCS and the hospital.

Additional Program Considerations

BHCS is considering three additional efforts that would expand services to meet the needs of the target population:

1. A new collaboration between local law enforcement and the BHCS Crisis Response Program to develop clinical “ride-along” teams. Police officers that have completed the BHCS Crisis Intervention Training would partner with behavioral health clinicians and this team would respond to police calls related to mental health needs.
2. An expansion of the Forensic Assertive Community Treatment (FACT) Team, to provide services to a greater number of incarcerated clients/consumers with mental illness. The FACT team is a component of the Behavioral Health Court.
3. Implementation of the Mentors on Discharge Program, which linked peer mentors to inpatient clients/consumers at John George Psychiatric Pavilion. Funded by an MHSA Innovations Grant, the program demonstrated a 67% decrease in hospital recidivism rates for clients/consumers that had a peer mentor upon their discharge.

Next Steps

BHCS Leadership is confident that these recommendations, when implemented as described, will expand and improve services for the types of clients/consumers identified in Laura’s Law. Most importantly, the recommendations will help to close the service gaps that stakeholders identified at the Laura’s Law public hearing and provide new types of support and assistance for family members. Given the complex challenges faced by those living with a mental illness, we know that no single program or approach will meet the needs of every client. However, each of the program recommendations are based on practices that have been successful in engaging clients/consumers and family members and demonstrating improvement in client and family outcomes. We will continue to research and analyze new and emerging programs that have the potential to meet client and family needs in Alameda County.

Dr. Aaron Chapman, the Interim Director, and Toni Tullys, Deputy Director, are available to meet with the Board of Supervisors and/or their staff to discuss these recommendations and respond to any questions or requests for additional information. As members of the BHCS Leadership Team, we are here to support the Board and Alameda County’s residents.