CITY OF SAN JOSE
CAPITAL OF SILICON VALLEY

Memorandum

TO: HONORABLE MAYOR AND CITY COUNCIL

FROM: Lee Wilcox

SUBJECT: **COUNTY OF SANTA CLARA BEHAVIORAL HEALTH PROGRAMS**

DATE: January 22, 2020

Approved [signature] Date 1-22-20

INFORMATION

At the November 20, 2019 Rules and Open Government Committee, the Administration was directed to submit a letter from the City of San José Mayor and City Council to the Santa Clara County Board of Supervisors and the County Administration requesting implementation of Laura's Law (Assisted Outpatient Treatment) as well as a strengthening of conservatorship policies for residents that struggle with serious mental illness. This item was again discussed at the December 10, 2019 City Council meeting under item 3.6[1] where a request was made for additional information regarding the Santa Clara County's expansion of Behavioral Health Services for adults and older adults, which was scheduled for implementation in fall 2019.

In response to Council direction, on December 12, 2019 a letter was submitted to the Santa Clara County Board of Supervisors on behalf of the City of San José Mayor and City Council (*Attachment A*).

Attached to this memorandum are two reports authored by Toni Tullys, Director of the County's Behavioral Health Services. The first report was submitted to the Health and Hospital Committee on August 22, 2019 providing an update on Assisted Outpatient Treatment (*Attachment B*). It summarizes the 2002 California Assembly Bill 1421 (Laura's Law) and its implementation in California through April 2017 as summarized by the State of California's Department of Health Care Services, Mental Health and Substance Use Disorder Services in its July 2018 Report. This memo also outlines the County's Behavior Health Services expansion of programs for its adult system of care.

[1] https://sanjose.legistar.com/LegislationDetail.aspx?ID=4263938&GUID=32623866-8137-46E7-8D24-DFCECA1C562B&Options=&Search=

The second memorandum was submitted to the Board of Supervisors on December 17, 2019 as part of a report requested by Supervisors Chavez and Cortese (Board Referral Item Number 16 ID#98761 approved on November 5, 2019)[2], which directed the Behavioral Health Services Department to provide options for consideration relating to the provision of safe places and support services for members of the community with high needs, who are severely mentally ill, dually diagnosed, and unhoused (*Attachment C*).

The Administration understands the Mayor and City Council's shared interest in ensuring that adequate and high quality resources are available and accessible to residents struggling with mental illnesses, substance use, or both. As part of its work in helping draft the Community Plan to End Homelessness, the City Manager's Office and Housing Department are working with their County partners to better assess the existing capacity of behavioral health resources against the need in the community. As the City moves from the planning and community engagement phases of this process to implementation of a San José-specific operational plan, the Administration will continue to advocate for the resources necessary to close any existing resource gaps.

/s/
LEE WILCOX
Chief of Staff, City Manager's Office

For questions, please contact Sarah Zárate, Assistant to the City Manager, at (408) 535-5601.

Attachments:
Attachment A: December 12, 2019 Letter to Board of Supervisors regarding Conservatorship in Santa Clara County
Attachment B: County of Santa Clara Behavioral Health Services Update on Assisted Outpatient Treatment (Laura's Law)
Attachment C: County of Santa Clara Behavioral Health Services Report on Safe Places and Support Services for Mentally Ill/Dually Diagnosed Individuals

[2] http://sccgov.iqm2.com/Citizens/Detail_LegiFile.aspx?Frame=SplitView&MeetingID=11147&MediaPosition=&ID=99307&CssClass=

ATTACHMENT A

CITY OF SAN JOSE
CAPITAL OF SILICON VALLEY

City Council

200 E. Santa Clara St., 18th Fl., San José, CA 95113 tel (408) 535-4900

December 12, 2019

Board of Supervisors
County of Santa Clara
70 West Hedding Street
San Jose, CA 95110

Re: Conservatorship in Santa Clara County

Dear Santa Clara County Board of Supervisors,

We write on behalf of the City of San José to encourage the County to pursue additional options in addressing mental health treatment for homeless individuals, including conservatorship. Currently the County of Santa Clara staff, Destination: Home, and City of San José staff are working to finalize a new Community Plan to End Homelessness—better aligning our goals and strategies. As we embark on implementing this plan we must collectively align our operations, resources, and policies to meet these goals.

To that end, we share the position outlined in the November 5, 2019 memo from Supervisors Chavez and Cortese that "the County of Santa Clara needs to act with urgency as it relates to providing safe places and supportive services to very vulnerable members of our community who are severely mentally ill, dually-diagnosed, unhoused and unable to proactively access community-based mental health services."

According to the 2019 City of San José Homeless Census and Survey, 42% of homeless survey respondents reported a psychiatric or emotional condition in the City of San José. Homeless individuals who lack capacity because of a severe mental illness to provide for their basic human needs cannot continue to fall victim to uninhabitable living conditions, drug and alcohol abuse, and risks of harm to themselves or others on the streets. It is imperative that we examine conservatorship options, including implementing Laura's Law in Santa Clara County for outpatient services and inpatient options to address a portion of this population's needs.

As you know, the State of California passed Laura's Law in 2002 to introduce court-mandated assisted outpatient treatment for those who are likely to benefit from it. To date, 20 counties in California have implemented Laura's Law, including the Bay Area Counties of San Mateo, Alameda, Contra Costa, Marin, and San Francisco. In San Francisco County, 91% of patients saw reduced hospitalization, with 88% reducing their time spent incarcerated, and 74% reducing their use of Psychiatric Emergency Services. Not only that, but in Nevada County, where Laura's Law was first implemented, the law has saved between $1.82 to $2.52 per $1.00 invested in the

program. Laura's Law is saving lives, saving money, and giving people the help that they need.

Additionally, in September of 2018, the State of California passed Senate Bill 1045, which allows the City and County of San Francisco, Los Angeles, and San Diego Counties to pilot a 5-year program of housing-based conservatorship. SB 1045 increases the responsiveness of courts to individuals lacking capacity to take care of their health and welfare by making available a conservatorship when those individuals are suffering from both a severe mental illness as well as a substance use disorder. Individuals that fail to qualify as "gravely disabled" often get stuck in a chronic cycle of coming in and out of 72-hour psychiatric holds, and are victims of a dysfunctional system that is in desperate need of reform. We encourage Santa Clara County to advocate for inclusion in this or comparable legislation that effectively treats the most vulnerable in our County.

We are heartened that the County is examining additional service needs for homeless individuals, including those suffering mental health disease and drug addiction. We share your goals of ending homelessness in our community, and look forward to continuing to collaborate on solutions.

Sincerely,

Mayor Sam Liccardo
on behalf of the City of San José City Council

C. County Administration
City Manager

COUNTY OF SANTA CLARA
Behavioral Health Services

DATE: August 22, 2019

TO: Health and Hospital Committee

FROM: Toni Tullys, Director, Behavioral Health Services

SUBJECT: Update on Assisted Outpatient Treatment (Laura's Law)

On June 19, 2019, at the request of Supervisor Ellenberg, the Behavioral Health Services Department (the Department) was asked to provide an update on Assisted Outpatient Treatment (AOT), also known as Laura's Law, at the August 2019 Health and Hospital Committee.

On September 13, 2017, the Department provided a detailed report to the Board of Supervisors (Board) through the Health and Hospital Committee related to the possible implementation of Assisted Outpatient Treatment (also known as Laura's Law), which allows using the judicial system when constituents are in high need of mental health services (LF # 88121). The report describes the history of the AOT legislation, the 2004 development of the Mental Health Services Act (MHSA), which emphasized voluntary programs, and the AOT goals, eligibility criteria and court process.

In 2002, California Assembly Bill 1421 (Laura's Law) authorized the provision of AOT which is defined as categories of outpatient services that have been ordered by a court per California Welfare and Institution Code (WIC) 5346. The bill was a result of a Nevada County shooting death of three people, including Laura Wilcox, by an individual with mental illness who was not participating in treatment. While the law was passed, it was not funded, leaving County Boards of Supervisors to decide whether or not they would implement AOT and how they would fund the program. Each County Board of Supervisors must approve AOT implementation in their county. Per state statute, no voluntary mental health programs may be reduced as a result of the implementation of AOT.

Update on California's AOT Implementation

While Nevada County implemented AOT in 2008 and Yolo County in 2013, the majority of counties who chose to implement AOT did not begin implementation until 2015-2016. As reported in the Department's September 2017 AOT report, 14

counties had implemented the program, three had adopted AOT, but had not implemented, and one county was considering AOT. Currently, 20 counties have implemented AOT as an available tool for people with serious mental illness who are unable and/or unwilling to participate in treatment and meet the criteria for AOT in the WIC 5346. The 20 counties are:

1. Alameda
2. Contra Costa
3. El Dorado
4. Kern
5. Los Angeles
6. Marin
7. Mendocino
8. Nevada
9. Orange
10. Placer
11. San Diego
12. San Francisco
13. San Luis Obispo
14. San Mateo
15. Santa Barbara
16. Shasta
17. Solano County
18. Stanislaus
19. Ventura
20. Yolo

AOT Evaluations and Results

In July 2018, the California Department of Health Care Services (DHCS) Mental Health and Substance Use Disorder Services released a report on Laura's Law: Assisted Outpatient Treatment Demonstration Project Act of 2002 (Attached). DHCS is required to establish criteria and collect outcomes data from counties that choose to implement the AOT program and to produce an annual report on the program's effectiveness, which is due to the Governor and Legislature annually by May 1. The attached report is based on May 2016 - April 2017 data, which was provided by six counties: Contra Costa, Los Angeles, Nevada, Orange, Placer and San Francisco. The Report Summary stated that there are three important developments for this reporting period:

1) Two additional counties provided data on AOT clients as compared to the previous reporting period,
2) The six counties that provided data to DHCS reported a positive impact on the three data items emphasized by the statute governing AOT (WIC Sections 5345-5349.5) – homelessness, hospitalizations, and incarcerations, and
3) Counties continue to report that few individuals require court involvement to participate in AOT services.

There were 63 court-ordered involved individuals in the six counties that provided data. A total of 380 individuals were served voluntarily by the six counties reporting data and the majority were in Los Angeles and Orange counties.

The programs reported that the majority of their AOT referrals responded to the initial invitation to participate in voluntary services and did not require a court petition or process. Counties reported that this is due to a successful engagement process, as most individuals referred for assessment accept the first offer for voluntary services. Many individuals due to their symptoms, do not immediately access mental health services, but may accept a voluntary service in response to county engagement efforts and to avoid a court process.

DHCS also identified several limitations of this analysis. While the data has increased since additional counties have implemented AOT programs, the number of court-ordered participants remains small and counties were not using standardized measures. There was no comparison and/or control group, so it was unknown as to whether the improvements were a result of AOT program services, or other factors. The report was based on aggregated outcomes of the 63 individuals from the six counties that reported court-ordered services.

In conclusion, the DHCS report indicated that the program was successful in reducing the need for hospitalizations and/or incarcerations, largely due to an increased amount of support and increasing employment during the reporting period.

Contra Costa and San Francisco Counties recently completed extensive evaluations of their AOT pilot programs. Contra Costa completed their evaluation in October 2018, following two and a half (2 ½) years of implementation, and served 80 individuals in the Assertive Community Treatment (ACT) program; 63 volunteered and 17 were court-ordered. San Francisco completed their three-year evaluation in March 2019 and 89 out of 129 individuals in the AOT program voluntarily engaged in services; 85 individuals remained connected to a treatment provider at the time of the evaluation. The AOT team provided clinical case management to 43 of these individuals (26 voluntary and 17 court ordered). Both counties reported positive client outcomes (decrease in crisis services, inpatient psychiatric hospitalization and incarceration), cost savings, and small numbers of court-ordered individuals.

Summary of Findings

A significant majority of individuals that have been referred and meet the criteria for AOT programs voluntarily accept services and achieve positive outcomes, including reductions in crisis/emergency psychiatric services, inpatient psychiatric hospitalization, homelessness and incarceration. There are small numbers of court-ordered clients in AOT programs, which cannot show statistical significance.

However, court-ordered clients have demonstrated individual progress and some have achieved the same types of positive outcomes as the voluntary clients.

Counties have developed and learned from AOT pilots, implemented AOT outreach, engagement and clinical teams to serve the population, and utilized Full Service Partnerships (FSPs) or ACT teams for clinical services. Consistent outreach and peer support have been important components to engage and support individuals in AOT services.

AOT program costs may vary based on each county, but the primary costs are for direct service staff, which often includes a program manager, clinical staff, peer workers and administrative support. Orange County and Nevada County estimated the AOT mental health treatment costs at $35,000 to $40,000 per person per year. This aligns with the estimated cost for the Department's new ACT program for adults with serious mental illness that need intensive outpatient services.

In reviewing the evaluations and discussing AOT services with county and consultant colleagues, AOT can be a useful tool to identify, engage and treat a small group of people with serious mental illness who would otherwise be unable to participate in services that they need. However, the data on court-ordered individuals enrolled is limited, and while AOT has produced positive outcomes, it will not engage every person with serious mental illness into services or every loved one that a family member cares about.

Expansion of Behavioral Health Services for Adults and Older Adults

Over the past year, the Department has implemented several new programs to address gaps, expand the continuum of care, outreach and engage individuals for services, and track and evaluate client/consumer outcomes. The intent of the new programs is to connect Adults/Older Adults into the appropriate services for their needs.

New programs include the County-operated In-home Outreach Team (IHOT), which will outreach to Emergency Psychiatric Services (EPS) clients/consumers and connect them to services, and the IHOT community-based teams that will serve clients/consumers and families across the county. For individuals in crisis, there is a Crisis Text Line (text RENEW to 74141) and Adult Mobile Crisis Response Teams that assess individual needs over the phone, identify and connect callers to services, and make home visits when needed. These new services are available 24/7.

Vendors have been selected to provide ACT and Forensic ACT (FACT) services, which are evidence-based and the highest level of outpatient services for individuals with serious mental illness. While these are new services in Santa Clara County, ACT and FACT have demonstrated positive and consistent consumer outcomes for many years and are designed for individuals coming out of hospitals or custody and/or those who need intensive and frequent services. In addition, new Intensive

Full Service Partnerships (FSPs) will provide "whatever it takes" mental health services for Transitional Age Youth, Adults and Older Adults. The ACT, FACT and Intensive FSPs will provide 800 new service slots for adult consumers. Substance Use Treatment Services has increased outpatient services by 220 slots and anticipates serving an additional 800 clients in the next year. Detoxification beds also have been increased from 28 to 36 with an expectation to serve over 500 clients.

The Department's expansion of Adult/Older Adult services was designed to outreach, engage, connect, and support individuals with serious mental illness and substance use disorders in voluntary, evidence-based services. The new ACT/FACT programs and Intensive FSPs are the same services utilized in the AOT programs. Implementation is planned for October 2019 and the Department expects an increase in the number of people receiving these intensive services and a decrease in EPS visits, psychiatric hospitalization, incarceration and homelessness over time.

Attachment:

- DHCS Laura's Law: Assisted Outpatient Treatment Demonstration Project Act of 2002, July 2018

Laura's Law: Assisted Outpatient Treatment Demonstration Project Act of 2002

For the Reporting Period
May 2016 – April 2017

Department of Health Care Services
Mental Health and Substance Use Disorder Services

JULY 2018

Table of Contents

EXECUTIVE SUMMARY

Assembly Bill (AB) 1421 (Thomson, Chapter 1017, Statutes of 2002) established the Assisted Outpatient Treatment Demonstration Project Act of 2002 in Welfare and Institutions Code (WIC) Sections 5345 – 5349.5, known as Laura's Law (named after one of the individuals killed during a 2001 incident in Nevada County, California).Laura's Law requires the Department of Health Care Services (DHCS) to establish criteria and collect outcomes data from counties that choose to implement the AOT program and produce an annual report on the program's effectiveness, which is due to the Governor and Legislature annually by May 1. Using data provided by participating counties, DHCS is required to provide an evaluation of the effectiveness of the county programs in developing strategies to reduce the clients' risk for homelessness, hospitalizations, and involvement with local law enforcement. This report serves as the May 1, 2017 annual report and provides outcomes for the May 2016 – April 2017 reporting period.

The table below shows a list of counties that have received Board of Supervisors approval to operate an AOT program, counties that submitted an AOT report to DHCS and, of those, which county AOT reports provided data to DHCS during this reporting period. Seventeen counties have Board of Supervisors approval to operate an AOT program: Alameda, Contra Costa, El Dorado, Kern, Los Angeles, Mendocino, Nevada, Orange, Placer, San Diego, San Francisco, San Luis Obispo, San Mateo, Santa Barbara, Stanislaus, Ventura, and Yolo[1]. During this reporting period, 12 counties submitted reports to DHCS: Alameda, Contra Costa, Kern, Los Angeles, Mendocino, Nevada, Orange, Placer, San Francisco, San Mateo, Ventura, and Yolo. Six of these counties had data to report on AOT court ordered or settled[2] individuals: Contra Costa, Los Angeles, Nevada, Orange, Placer and San Francisco. The remaining six programs did not have court-ordered individuals or had too little data for the reporting year to report to DHCS, but provided information on their programs' progress. Accordingly, this report reflects aggregate outcomes for 63 individuals from the six counties that reported court-ordered or settled AOT client data to DHCS. This is more than double the number of participants compared to the previous 2015-16 reporting period, which included 28 court-involved individuals in AOT programs.

Participating County Implementation and Reporting Status (as of April 2017)*

County	Board of Supervisors Approval	Submitted a Report to DHCS	Report Included AOT Data
Alameda	X	X	
Contra Costa	X	X	X
El Dorado	X		
Kern	X	X	

[1] Stanislaus County received board of supervisor approval to implement a pilot program in April 2018. Since this occurred after the reporting period, data for Stanislaus is not reflected in this report.
[2] Court "settled" means that the individual receives services through a court settlement, rather than a hearing.

County	Board of Supervisors Approval	Submitted a Report to DHCS	Report Included AOT Data
Los Angeles	X	X	X
Mendocino	X	X	
Nevada	X	X	X
Orange	X	X	X
Placer	X	X	X
San Diego	X		
San Francisco	X	X	X
San Luis Obispo	X		
San Mateo	X	X	
Santa Barbara	X		
Stanislaus	X		
Ventura	X	X	
Yolo	X	X	

*Stanislaus County received board of supervisor approval to implement a pilot program in April 2018. Since this occurred after the reporting period, data for Stanislaus is not reflected in this report.

2016-17 Report Summary

There are three important developments for this reporting period: 1) two additional counties provided data on AOT clients as compared to the previous reporting period, 2) the six counties that provided data to DHCS reported a positive impact on the three data items emphasized by the statute governing AOT (WIC Sections 5345-5349.5) – homelessness, hospitalizations, and incarcerations, and 3) counties continue to report that few individuals require court involvement to participate in AOT services. In this reporting period, there were 63 court-involved individuals in the six counties that provided data[3].

Laws governing AOT programs require individuals whose cases are court-ordered or settled to receive services in a program that also provides the same services to individuals who are participating in the program voluntarily. Individuals referred for an AOT assessment must be offered voluntary services first before a court petition is considered. The programs reported that the majority of their AOT referrals responded to the initial invitation to participate in voluntary services, and did not require a court petition or process. Counties report that this is due to a successful initial engagement process, as most individuals referred for assessment accept the first offer for voluntary services. Many individuals, due to the symptoms of their mental illness, do not initially access local mental health services, but may accept a voluntary services offer

[3] 380 individuals were served voluntarily by the six counties reporting data, the majority were in Los Angeles and Orange counties.

in response to county engagement efforts and to avoid a court process.

Due to the small number of court-ordered or settled individuals in each county AOT program, health privacy laws prevent DHCS from reporting specific numbers on each of the required outcomes. This report reflects the following aggregate findings for the AOT program clients, using data for the six counties that reported data from their AOT services, which were provided during this reporting period:

- Homelessness decreased amongst individuals participating in the program.
- Hospitalization decreased amongst individuals participating in the program.
- Contact with law enforcement decreased amongst individuals participating in the program.
- Most individuals remained fully engaged with services.
- Some individuals were able to secure employment.
- Little victimization[4] was reported for individuals in the program.
- Violent behavior decreased during the reporting period for some individuals.
- Some clients had co-occurring diagnoses. Many of those individuals were able to reduce substance use.
- Some clients were subject to enforcement mechanisms[5] ordered by the court during AOT. Some of these individuals were involuntarily evaluated, many had additional status hearings, and many received medication outreach.
- Many individuals achieved moderate to moderately high levels of social functioning.
- Some clients agreed to participate in satisfaction surveys and indicated high levels of satisfaction with services.

There are several noteworthy limitations of DHCS' analysis. Although the reportable data has increased since additional counties have implemented AOT programs, court-ordered participant numbers remain small and counties are not using standardized measures. This makes it difficult to make a comparable evaluation across counties, and further, there is no comparison and/or control group, so it is unknown as to whether or not all of the improvements in participant outcomes were a result of AOT program services or if other factors were involved. Some of the measures are based on self-reports and/or recollections of past events, which may or may not be accurate or reliable. Furthermore, individuals were followed for different periods of time (e.g., individual A may have been followed for one week, while individual B may have been followed for the entire reporting year). As with other programs that have transitory populations in different phases of program completion, there may be carry over data from the prior reporting year. Despite these limitations, the data submitted by counties indicate improvements to many of the reported outcomes for individuals who were served during this reporting period.

[4] Victimization is based on county definitions and reports of victimization include descriptions of the incidents.
[5] Examples of enforcement mechanisms used by courts include, but are not limited to, involuntary evaluation, increased number of status hearings, and medication outreach.

INTRODUCTION

AB 1421 (Thomson, Chapter 1017, Statutes of 2002) established the Assisted Outpatient Treatment (AOT) Demonstration Project Act of 2002, known as Laura's Law. AB 1569 (Allen, Chapter 441, Statutes of 2012) extended the sunset date for the AOT statute from January 1, 2013, to January 1, 2017; and AB 59 (Waldron, Chapter 251, Statutes of 2016) extended the sunset date for the AOT statute until January 1, 2022, and added the Governor as a direct recipient of this report. The program was transferred from the former Department of Mental Health (DMH) to the Department of Health Care Services (DHCS) and incorporated into DHCS' county mental health performance contracts with the enactment of SB 1009 (Committee on Budget and Fiscal Review, Chapter 34, Statutes of 2012).

DHCS is required to annually report to the Governor and Legislature on the effectiveness of AOT programs by May 1 of every year. Pursuant to WIC Section 5348, effectiveness of AOT programs is evaluated by determining whether persons served by these programs:

- Maintain housing and participation/contact with treatment;
- Have reduced or avoided hospitalizations; and
- Have reduced involvement with local law enforcement, and the extent to which incarceration was reduced or avoided.

To the extent data are provided by participating counties, DHCS must also report on:

- Contact and engagement with treatment;
- Participation in employment and/or education services;
- Victimization;
- Incidents of violent behavior;
- Substance use;
- Required enforcement mechanisms;
- Improved level of social functioning;
- Improved independent living skills; and
- Satisfaction with program services.

The AOT statute provides a process for designated individuals who may refer someone to the county mental health department for an AOT petition investigation. In order for an individual to be referred to the court process, the statute requires certain criteria to be met, voluntary services to be offered, and options for a court settlement rather than a hearing to be provided.

BACKGROUND

The statutory requirements for Laura's Law do not require counties to provide AOT programs and do not appropriate any additional funding to counties for this purpose. For many years, only Nevada County operated an AOT program. The passage of SB 585 (Steinberg, Chapter 288, Statutes of 2013) authorized counties to utilize specified funds for Laura's Law services, as described in WIC Sections 5347 and 5348. Since the enactment of this legislation, an increasing number of counties have implemented AOT. See Appendix A for a history of AOT in California.

Implementation of Laura's Law

The table below shows a list of counties who have received Board of Supervisors approval to operate an AOT program, counties that submitted an AOT report to DHCS and, of those, which county AOT reports provided data to DHCS during this reporting period. Seventeen counties have Board of Supervisors approval to operate an AOT program: Alameda, Contra Costa, El Dorado, Kern, Los Angeles, Mendocino, Nevada, Orange, Placer, San Diego, San Francisco, San Luis Obispo, San Mateo, Santa Barbara, Stanislaus, Ventura, and Yolo.[6] Most AOT programs are still in early implementation stages and have few or no clients who are court-ordered or settled.

The following 12 counties submitted reports to DHCS on their AOT programs for the reporting period: Alameda, Contra Costa, Kern, Los Angeles, Mendocino, Nevada, Orange, Placer, San Francisco, San Mateo, Ventura, and Yolo. Of these, Contra Costa, Los Angeles, Nevada, Orange, Placer, and San Francisco counties had data to report based on the individuals participating in their AOT programs that were court-ordered and/or settled. Kern and Yolo Counties reported on their programs, but did not yet have any individuals in AOT programs or did not have enough data to include. Alameda, Mendocino, San Mateo, and Ventura Counties reported on their new programs, but did not have clients during most of the reporting period, and therefore did not have enough data to include.

Participating County Implementation and Reporting Status (as of April 2017)*

County	Board of Supervisor Approval	Submitted a Report to DHCS	Report Included AOT Data
Alameda	X	X	
Contra Costa	X	X	X
El Dorado	X		
Kern	X	X	
Los Angeles	X	X	X
Mendocino	X	X	
Nevada	X	X	X
Orange	X	X	X

[6] Stanislaus County received board of supervisor approval to implement a pilot program in April 2018. Since this occurred after the reporting period, data for Stanislaus is not reflected in this report.

County	Board of Supervisor Approval	Submitted a Report to DHCS	Report Included AOT Data
Placer	X	X	X
San Diego	X		
San Francisco	X	X	X
San Luis Obispo	X		
San Mateo	X	X	
Santa Barbara	X		
Stanislaus	X		
Ventura	X	X	
Yolo	X	X	

* Stanislaus County received board of supervisor approval to implement a pilot program in April 2018. Since this occurred after the reporting period, data for Stanislaus is not reflected in this report.

DATA COLLECTION AND REPORTING METHODOLOGY

Most counties have implemented their AOT programs as part of their Mental Health Services Act (MHSA) Full Services Partnership (FSP) programs. Welfare and Institutions Code §5348(d) sets forth the reporting requirements for both the counties and the State and lists the required data elements that, if available, must be included. As a result, counties obtain data for AOT clients from some or all of the following sources:

- Client intake information
- MHSA FSP Outcome Evaluation forms
    - Partnership Assessment Form – The FSP baseline intake assessment.
    - Key Event Tracking (KET) – Tracks changes in key life domains such as employment, education, and living situation.
    - Quarterly Assessment – Tracks the overall status of a partner every three months. The Quarterly Assessment captures data in different domains than the KETs, such as financial support, health status, and substance use.
- "Milestones of Recovery Scale" (MORS) [7]
- Global Assessment of Functioning – Indicates the level of presence of psychiatric symptoms.

[7] This scale was developed from funding by a Substance Abuse and Mental Health Services Administration grant and designed by the California Association of Social Rehabilitation Agencies and Mental Health America Los Angeles researchers Dave Pilon, Ph.D., and Mark Ragins, M.D., to more closely align evaluations of client progress with the recovery model. Data collected from the MORS is used with other instruments in the assessment of individuals functioning level in the Social Functioning and Independent Living Skills sections. Engagement was determined using a combination of MORS score improvement, contact with treatment team tolerance and social activity.

- Mental Health Statistics Improvement Program Consumer Surveys – Measure matters that are important to consumers of publicly funded mental health services in the areas of access, quality, appropriateness, outcomes, overall satisfaction, and participation in treatment planning

Counties collected and compiled the required information into written reports, which were submitted to DHCS. Due to the small population sizes reported, AOT clients may be identifiable. DHCS is committed to complying with federal and state laws pertaining to health information privacy and security.[8] In order to protect clients' health information and privacy rights, summary numbers for each of the specified outcomes cannot be publicly reported. In order for DHCS to satisfy its AOT program evaluation reporting requirement, as well as protect individuals' health information, DHCS adopted standards and procedures to appropriately and accurately aggregate data, as necessary.

[8] Federal laws: Privacy Rule and the Security Rule contained in the Health Insurance Portability and Accountability Act and clarified in Title 45 Code of Federal Regulations Part 160 and Subparts A and E of 164. State Laws: Information Practices Act and California Civil Code Section 1798.3, et. seq.

FINDINGS FOR REPORTING PERIOD May 1, 2016 – April 30, 2017

Based on county-reported data, there are very few individuals entering the AOT programs as a result of court orders or settlements. Individuals referred for an AOT assessment must be offered voluntary services before a court petition is considered. The programs reported that the majority of their AOT referrals responded to the initial invitation to voluntary services and did not require a court petition or process. Counties report that this is due to a successful initial engagement process, as most individuals referred for assessment accept the first offer for voluntary services.

Although 16 counties have implemented AOT programs, the data summarized in this report reflect the six counties that had data for court-ordered or settled individuals. Data for these counties are aggregated, with highlights of each program listed first. The six counties' AOT programs collectively served a total of 63 court involved individuals. This is more than double the number of participants as compared to the last reporting period, in which 28 individuals were in AOT programs.

Part I: County Programs Serving AOT Court-Involved Individuals – Contra Costa, Los Angeles, Nevada, Orange, Placer, and San Francisco

County Program Unique Highlights

Contra Costa County reported that, during its first year of operation, 91 percent of individuals referred for assessment for AOT services accepted voluntary services.

Los Angeles County reported serving voluntary clients since 2010 in a pilot AOT program. The county then fully implemented and expanded its AOT program in 2015. This is the first reporting year that Los Angeles has had court-ordered or settled AOT participants. As with the other counties, the Los Angeles court-ordered or settled participants are a fraction of its overall number of AOT participants.

Nevada County has had the longest running AOT program, dating back to 2008. Consistently over that time, the majority of the referred individuals accepted the program's invitation to participate in voluntary services rather than requiring a court-order or settlement.

Orange County noted that, while there was overall improvement in housing over the reporting period, participants still experienced challenges finding and maintaining housing.

Placer County continues to be in the early stages of providing AOT services to individuals and has a small number of participants.

San Francisco County has developed an AOT Care Team, which is responsible for AOT court petitions and advocating for AOT individuals with preexisting charges to be referred to collaborative courts such as Behavioral Health Court. Behavioral Health Court is focused on family support including offering resources such as a Family Liaison, information, and assistance navigating the mental health and criminal justice systems. San Francisco County continues to host a quarterly conference call with other counties that have implemented AOT to share information and experiences of AOT programs.

Demographic Information

Counties reported that the majority of participating individuals were Caucasian males between ages 26 and 59. This is similar to the information from the last reporting period, which indicated the majority of individuals in the programs were males identifying as Caucasian between 26 and 59 years of age. Some counties reported seeing more racial diversity in their AOT populations, and more female participants.

Homelessness/Housing

In the previous reporting period, homelessness among those served decreased. For this reporting period, counties reported modest reductions in homelessness, with the majority of clients obtaining and maintaining housing while in the AOT program.

Hospitalization

In the last reporting period, many of the individuals who were hospitalized prior to receiving AOT services experienced decreases in their hospitalization days. This reporting period, most programs reported that the majority of clients with psychiatric hospitalizations prior to AOT either reduced their days of hospitalization during AOT or entirely eliminated hospitalizations.

Law Enforcement Contacts

In the last reporting period, programs reported law enforcement contacts (measured as “days of incarceration”) were reduced for all individuals that had experienced incarceration days prior to AOT. For this reporting period, this trend continues as all programs reported reductions in law enforcement contact for participants in AOT programs.

Treatment Participation / Engagement

For the previous reporting period, participants’ ability to engage and participate in treatment varied significantly. Counties indicated that programs focused on assisting individuals with critical symptoms who were reluctant to approach treatment, and most participants were able to achieve at least moderate levels of engagement. For this reporting period, the majority of the participants again were able to engage in treatment and remain in contact with their programs. This continues to result in positive outcomes for reducing hospitalizations, incarcerations, and homelessness.

Employment

In the prior reporting period, few clients were employed while in the program. Generally, clients were either not far enough along in treatment to gain employment or the AOT program had not yet implemented employment services as a component. For this reporting period, there was an increased level of employment for individuals across programs, including some participation in education.

Victimization

For the previous reporting period, there were few reported instances of victimization for participants prior to AOT program participation, and none reported for individuals during their AOT program participation. For this reporting period, there were again few reports of victimization, with some programs reporting that individuals were reluctant to share such information via the questionnaires that were used. These programs indicate that they will modify their questionnaires and/or programs to provide more comfortable means for individuals to share such sensitive information.

Violent Behavior

In the prior reporting period, counties reported an overall decrease in violent behavior. In the current reporting period, some programs reported violent episodes for individuals who were struggling with initial phases of stability, and other programs reported that the AOT program participants displayed decreased violent behavior or that they did not collect data on this outcome measure.

Substance Abuse

During the last 2015-16 reporting period, one AOT program reported a decrease in substance use for the majority of its clients; however, most AOT programs could not report on the AOT program's impact on substance use due to lack of information provided by the participants.

For the 2016-17 reporting period, all programs reported varying levels of challenges with participant substance use. The majority of individuals in AOT have co-occurring diagnoses, meaning that they have both mental health and substance use disorder diagnoses. This presents a complication for programs to support individuals in recovery from both issues. In some cases, the majority of individuals in the programs relapsed during AOT, while other programs reported the majority were able to avoid substance use.

Enforcement Mechanisms

For the last reporting period, medication outreach (e.g., visiting clients to discuss medication, helping prepare medication boxes) was the enforcement mechanism used most often to support individuals who experienced challenges in managing and regularly administering their own medications. Some programs used status hearings as a vehicle to help individuals re-focus on their treatment goals and self-care when they were

missing appointments and their mental health was beginning to decompensate.

For this reporting period, the most common enforcement mechanisms used were additional status hearings, with a small group of individuals receiving orders for hospitalization for the purpose of psychiatric evaluation. Some programs provided medication outreach as a regular support for their participants.

Social Functioning

For the prior reporting period, all AOT programs provided DHCS with anecdotal information on clients' increased social functioning, generally credited to the staff's ability to develop good rapport with the clients.

For this reporting period, overall, AOT programs reported increased social functioning and considered the participants' ability to interact with staff and tolerate therapeutic interactions a significant outcome in this area.

Independent Living Skills

For the last reporting period, most programs communicated to DHCS that the participants needed guidance with a wide array of independent living skills, such as medication management, money management, housing maintenance, and activities of daily living (e.g., dental hygiene), especially those who were generally homeless or frequently hospitalized prior to the court order.

During this period, programs reported that the majority of individuals improved in their independent living skills, as indicated by improved scores on the Milestone of Recovery Scale, and demonstrated strengthened skills in stress management, improved hygiene, food preparation, and transportation.

Satisfaction with Services

For the last reporting period, most AOT programs leveraged the annual Mental Health Statistics Improvement Program to report satisfaction with services. Because satisfaction surveys are voluntary, some clients refused to complete them. AOT Programs that surveyed clients and families found that the majority responded positively about the program and services.

For this reporting period, the majority of surveyed individuals were also satisfied with their services. Some programs have or are developing their own survey tool to capture individual responses that are unique to AOT programs rather than utilizing a pre-established survey, which include services beyond AOT.

Part II: Programs with No AOT Court Ordered Individuals – El Dorado, Kern, Mendocino, San Diego, San Luis Obispo, San Mateo, Santa Barbara, Ventura, and Yolo Counties

County Program Unique Highlights

El Dorado County is implementing AOT by conducting a pilot program and currently has voluntary clients.

Kern County began services in Fall 2015 and continues to have only voluntary clients during both the current and previous reporting periods.

Mendocino County has implemented a four-slot pilot program for AOT and had no court-ordered or settled participants.

San Diego County just completed the first year of their new program with no court-ordered or settled participants.

San Luis Obispo County is still in the early stages of implementing their new program.

San Mateo County assembled a team consisting of a Clinical Services Manager, one half-time Psychologist, one Psychiatric Social Worker, one half-time Deputy Public Guardian and two half-time Peer Support Workers that travel throughout the county to evaluate individuals and provide referrals to services if needed. San Mateo County includes a Peer Support Worker to enhance engagement and support for individuals encountering the AOT program.

Santa Barbara County did not have a full year of the new program for this reporting period and did not have any court-ordered or settled participants.

Ventura County recently began receiving individuals, but did not have any during the reporting period.

Yolo County has a five slot AOT program, which was implemented three years ago. To date, it has only voluntary individuals have utilized the program.

Summary of Programs

The numbers of individuals participating in AOT services statewide has increased since more counties have implemented AOT programs. Programs report that ongoing efforts to develop robust engagement and support strategies have led to more engaged participation in AOT programs and voluntary participation in AOT services. With continued success in this area, programs are likely to maintain low numbers of individuals that require court involvement.

LIMITATIONS

There are several noteworthy limitations of DHCS' analysis. Although participating counties have provided additional data, court ordered client numbers remain small. The small population size makes it difficult to determine if the data allows for statistically significant conclusions. Additionally, counties are not using standardized measures, which makes it difficult to make comparisons across counties. Further, there is no comparison and/or control group, so it is unknown as to whether or not the improvements were a result of AOT program services, or other factors. Some of the measures are based on self-reports and/or recollections of past events, which may or may not be accurate or reliable. Furthermore, individuals were followed for different periods of time (e.g., individual A may have been followed for one week, while individual B was followed for the entire reporting period). As with other programs that have transitory populations in different phases of program completion, there may be carry over data from the prior reporting period.

Despite these limitations, DHCS' analysis suggests improved outcomes for AOT program participants served during the reporting period. Notably, the majority of individuals referred for an assessment opt to engage in voluntary AOT program services after being offered those services as part of the assessment process.

DISCUSSION

The data provided by counties suggest that individuals have benefited from participation in AOT programs, as evidenced by reductions in hospitalizations, homelessness, contact with law enforcement, and substance use. With respect to individuals that have both substance use and mental health issues, it is important to understand that concurrently recovering from both represents enormous challenges and requires a great deal of support and counseling. Some counties found that there were challenges with participants relapsing and at times relapses lead to further psychiatric hospitalizations.

Prior to participating in an AOT program, many individuals' experience with mental health treatment mainly involved locked facilities or hospitalization. Therefore, many clients had to adjust to forming relationships with supportive community mental health workers and to receiving intensive services outside of a locked setting. The success of this adjustment was indicated by the engagement by most individuals in AOT programs overall, whether voluntary or involuntary, and by the majority of individuals who completed a satisfaction survey indicating that they were satisfied with the services and supports.

Counties continue to report that only a small fraction of their overall AOT program populations (voluntary plus involuntary individuals) require a court order or settlement to participate. This suggests that counties are maintaining a strong effort to engage individuals in voluntary services and avoiding the court petition process.

CONCLUSION

Seventeen counties currently have Board of Supervisors approval to operate an AOT program. During this reporting period, 12 counties submitted reports to DHCS, six of which had data to report on AOT court-ordered or settled individuals. The other reporting AOT programs did not have court-ordered or settled client data to report to DHCS, but provided information on their programs' progress. This report includes aggregate outcomes from 63 individuals from the six counties that reported court-ordered or settled AOT client data to DHCS.

The data indicates that the program was successful in reducing the need for hospitalizations and/or incarcerations, largely due to an increased amount of support, and increasing employment during this reporting period. DHCS recommends continuing to monitor the progress and effectiveness of the services in the programs as counties develop and expand their programs, and ensuring that any other counties that choose to implement Laura's Law report data to DHCS, as required.

Appendix A

History of Involuntary Treatment and the Development of Laura's Law in California

Among significant reforms in mental health care, the Lanterman-Petris-Short (LPS) Act (Chapter 1667, Statutes of 1967) created specific criteria by which an individual could be committed involuntarily to an inpatient locked facility for a mental health assessment to eliminate arbitrary hospitalizations. To meet LPS criteria, individuals must be a danger to themselves or others, or gravely disabled due to a mental illness (unable to care for daily needs). Following LPS, several state hospitals closed in 1973 to reduce the numbers of individuals housed in hospitals, and the intent at the time was to have communities provide mental health treatment and support to these discharged patients. However, due to limited funding, counties were unable to secure the resources necessary to provide adequate treatment or services. As a result, many of the individuals released from the hospitals ended up homeless or imprisoned with very little or no mental health treatment.[9]

In 1999, the state of New York (NY) passed a law that authorized court-ordered AOT for individuals with mental illness and a history of hospitalizations or violence requiring that they participate in community-based services appropriate to their needs. The law was named Kendra's Law in memory of a woman who died after being pushed in front of a New York City subway train by a man with a history of mental illness and hospitalizations. Kendra's Law defines the target population to be served by the AOT programs as "….mentally ill people who are capable of living in the community without the help of family, friends and mental health professionals, but who, without routine care and treatment, may relapse and become violent or suicidal, or require hospitalization." The program is required in all counties in NY and the individuals served by court order have priority for services. Kendra's Law improved a range of important outcomes for its recipients,[10] but differs from California's Laura's Law in two significant ways. It requires that all counties in NY implement AOT programs, and requires that the clients accessing these programs have priority for services.

Patterned after Kendra's Law, California passed AB 1421 (Thomson, Chapter 1017, Statutes of 2002), known as Laura's Law, that provides for court-ordered community

[9] For additional historical information, see Laura's Law legislative report 2011 at: http://www.dhcs.ca.gov/services/MH/Documents/4LaurasLawFinalReport.pdf

[10] See Kendra's Law, Final Report on the Status of Assisted Outpatient Treatment Outcomes for Recipients during the First Six Months of AOT [Office of Mental Health, State of New York 2005, http://www.omh.ny.gov/omhweb/kendra_web/finalreport/outcomes.htm] and the New York State Assisted Outpatient Treatment Program Evaluation [Swartz, MS et al. Duke University School of Medicine, Durham, NC, June, 2009, http://www.macarthur.virginia.edu/aot_finalreport.pdf].

treatment for individuals with a history of hospitalization and contact with law enforcement. It is named after a woman who was one of three killed in Nevada County by an individual with mental illness who was not following his prescribed mental health treatment. The legislation established an option for counties to utilize courts, probation, and mental health systems to address the needs of individuals who are unable to participate on their own in community mental health treatment programs without supervision. Laura's Law authorizes counties to implement an AOT program and specifies that funding for established community services may not be reduced to accommodate the program. Laura's Law has resulted in reductions in homelessness, incarceration, and hospitalization for these individuals.

County of Santa Clara
Santa Clara Valley Health & Hospital System
Mental Health Services

99307

DATE: December 17, 2019

TO: Board of Supervisors

FROM: Toni Tullys, Director, Behavioral Health Services

SUBJECT: Report on Safe Places and Support Services for Mentally Ill/Dually Diagnosed Individuals

RECOMMENDED ACTION

Under advisement from November 5, 2019 (Item No. 16): Receive report relating to safe places and support services for individuals who are mentally ill and dually diagnosed. (Behavioral Health Services Department)

FISCAL IMPLICATIONS

This is an informational report; therefore, there is no net fiscal impact as a result of this action.

CONTRACT HISTORY

Not applicable.

REASONS FOR RECOMMENDATION

At the request of Supervisor Chavez and Supervisor Cortese, Board Referral Item Number 16 (ID# 98761) approved on November 5, 2019, directs the Behavioral Health Services Department (Department) to provide a report on December 17, 2019 with options for consideration relating to the provision of safe places and support services for members of the community with high needs, who are severely mentally ill (SMI), dually diagnosed, and unhoused.

The following report addresses the options available to enhance engagement and provide support to provide for this population's safety and wellbeing. In addition, these options would help ensure that traditionally hard to engage members of the community would be able to gain access to and sustain participation in services that are safe and available day and night.

To better evaluate the potential options for enhancing engagement with services, included below is an overview of the support services the County currently provides for high needs, SMI, dual diagnosed, and unhoused people.

This Fall, in an effort to increase the services available for this population, the Department stood up the Assertive Community Treatment (ACT) Program, Forensic Assertive Community Treatment (FACT) Program and the In-Home Outreach Team (IHOT). Additionally, the Department has selected vendors to provide Intensive Full-Service Partnerships (IFSPs), which are based on the ACT model. These services will provide 800 new service slots for adult/older adult consumers. Substance Use Treatment Services (SUTS) has increased outpatient services by 220 slots and anticipates serving an additional 800 clients in the next year. Community-based detoxification beds also have been increased from 28 to 36 with an expectation of serving over 500 clients.

To ensure that clients/consumers and family members could provide their suggestions on the new and expanded services, the Department held a Peer and Family Support Services Discussion Group Meeting on December 5, 2019. Clients/consumers, peer workers, family members and National Alliance on Mental Illness (NAMI) staff met with Department leaders and senior managers to share their ideas for the service delivery system.

Intensive Services Launched Fall 2019

The ACT program is a long-standing evidence-based practice that has been widely used across the country for individuals with intensive mental health needs. With fidelity to the ACT model, outcomes are positive for high need clients. The ACT program will provide a comprehensive approach to serve 200 severely mentally ill individuals and will assist the homeless, severely mentally ill and individuals with both mental illness and substance use disorders by using a multi-disciplinary team approach to care. The treatment will include a psychiatrist, nurse, case managers, and peer support workers. The program is characterized by 1) low client to staff ratio, 2) a shared caseload among team members providing a coordinated care approach to service delivery, and 3) 24-hour staff availability. Referrals for this level care of care can occur through system partners such as the Office of the Public Guardian (OPG), the Office of Supportive Housing (OSH), and Whole Person Care (WPC).

The FACT Program serves high-risk criminal justice-involved adults (ages 18 to 59) and older adults (ages 60 and over) with severe and persistent mental health and/or co-occurring conditions that result in substantial functional impairments or symptoms. Due to the recalcitrant nature of their symptoms, these individuals are more likely to experience a high utilization and repetitive cycle of incarceration, homelessness, substance use, crisis, and/or hospitalization.

The FACT team, upon making a determination that the consumer has a history of chronic homelessness, will complete the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) to quickly assess the health and social needs of homeless individuals - matching them with the most appropriate services, support and housing interventions available. Immediate assistance with securing supported housing arrangements, including linkage to safe and permanent housing upon graduation from FACT, will be provided to these individuals.

The provision of FACT services will result in a diversion of individuals from correctional/judicial systems and higher levels of care which in turn will help reverse the cycle of ongoing criminal justice involvement. From the inception of treatment, FACT teams will address housing challenges for this population by conducting the VI-SPDAT which will play a critical role in addressing resistance from participants around housing, finding appropriate housing options for this population, and teaching participants skills necessary to live independently. This will prepare the individual for a more seamless transition into long-term permanent housing.

Pay for Success "Partners in Wellness" Update and Outcomes

On October 18, 2019, the Department submitted an off-agenda report to the Board of Supervisors on the outcomes to date of the County's Pay for Success "Partners in Wellness" program. (Attached) In 2015, the Office of the County Executive ("County") recognized that the Department cared for many high-need individuals who make extensive use of 24-hour psychiatric services (e.g., EPS, Barbara Aarons Pavilion, Institutes of Mental Disease (IMDs) and contract inpatient psychiatric hospitals) without finding stable recovery in the community. This was obviously hard on those clients and posed significant fiscal and logistical challenges for the county. To serve such individuals more effectively, while also being a good steward of public funds, the County launched a highly innovative "pay for success" mental health initiative in 2016.

The Department contracted with Telecare Corporation, the selected vendor in a procurement process, to provide a package of ACT and Supported Housing to individuals who both experience serious mental illness and have a history of extensive, repeated 24-hour psychiatric service utilization.

The Telecare agreement included two key components. First, individuals were randomly assigned to Telecare versus standard services, which will allow a rigorous assessment of the project's conclusion about its clinical impact on clients. Second, under a novel financial agreement, Telecare would receive financial bonuses if it were unusually successful at reducing unnecessary 24-hour psychiatric utilization and would face financial penalties if they were not successful in this task.

During the first evaluation period (January 1, 2017 – June 30, 2017) and the second evaluation period (July 1, 2017 -June 30, 2018), Telecare patients required substantially lower than expected 24-hour psychiatric services. This included Telecare exceeding targets for reduced use of acute BAP services by 50% and use of IMDs by over 60%. For both periods, Telecare received the maximum pay for success bonus because they had overperformed so significantly. Analysis of the third evaluation period (July 1, 2018 – June 30, 2019) is nearly complete and while not finalized, again indicates very strong performance by Telecare at reducing psychiatric utilization.

As noted above, the Department has implemented ACT across the Adult and Older Adult (AOA) System with the goal of improving outcomes for all clients that would benefit from this level of care.

In-Home Outreach Team Launched Fall 2019

The IHOT is comprised of county-operated and contracted providers. This program is designed to 1) serve as an after-care program for individuals referred by law enforcement to the Mobile Crisis Response Team (MCRT). The IHOT will provide intensive outreach services by engaging the individuals and linking them to on-going services. The county-operated IHOT will also coordinate with Emergency Psychiatric Services (EPS) and provide outreach and engagement services to individuals who do not meet the criteria for inpatient hospitalization but require assistance in linkage to on-going outpatient services. Finally, the IHOT will serve as a care coordination team for individuals who may be receiving services through the OSH or through a conservatorship.

Enhanced Street Outreach and Engagement

Since the implementation of the Homeless Mentally Ill Outreach and Treatment (HMIOT) program, over 200 VI-SPDAT assessments have been completed. When HMIOT identifies homeless individuals with mental illness, they are referred to the HMIOT clinical outreach team. Currently, over 40 clients are enrolled and actively working with the clinical outreach team for continual engagement, crisis intervention, and linkage to services. Among those enrolled in HMIOT program, there was zero utilization of EPS. This is a 100% reduction in EPS services. The clinical outreach team responds to special cases addressing the needs of the homeless severely mentally ill individuals on the streets. As needed and as appropriate these individuals are assessed, provided with basic needs, interim housing/shelter, and continual follow up until they are linked to services. Among those who are enrolled with the clinical outreach team, over 50% are enrolled in Permanent Supportive Housing (PSH) programs, waiting for housing to become available.

Expansion of Wellness and Drop-In Centers

The Department continues to work on implementing culturally specific wellness and drop-in centers countywide. A Request for Proposal (RFP) to expand Wellness Centers and other community-based support services will be released in December 2019. These centers are designed to help create access and linkage to behavioral health treatment for unserved and underserved individuals and their families using strategies that are non-stigmatizing. Unlike the traditional Medi-Cal authorized services, the drop-in centers will operate using an open-door policy, whereby individuals not diagnosed with behavioral health-related disorders will also be welcome and free to attend. These wellness or drop-in centers can be co-located with non-clinical cultural services. These centers are expected to begin operations in July 2020.

The Call Center: "No Wrong Door" Approach

Through the use of updated workflows, additional staff training, and technology enhancements, the Call Center has implemented a concept typically referred to as the "No Wrong Door" approach. While supporting the Department's compliance with network adequacy requirements, this concept has also proved to be beneficial in supporting individuals with coexisting mental health and substance abuse problems. Using this approach, individuals are connected to the appropriate services, resulting in "no wrong door" for access to these services. This includes services related to "same-day" access, and/or direct access to both mental health and substance use treatment services. With the new and expanded levels of care, individuals can more easily be directed or transitioned to levels of service which best meet their needs.

Crisis Stabilization Unit and Sobering Center

These are two distinct services that are offered by the Department. The Crisis Stabilization Unit (CSU) program provides up to 23 hours of psychiatric care to individuals experiencing a mental health crisis. The CSU provides crisis intervention, crisis stabilization, limited medical evaluation, and support. The program offers linkages to culturally and linguistically appropriate follow-up care for outpatient individuals within the Department's continuum of care. Individuals can be brought in by law enforcement, be referred by community providers, or receive referrals from the EPS for follow-up care and coordination.

The Sobering Center provides up to 23 hours of care to individuals that are under the influence of alcohol. This program provides support during the individual's stay while they dissipate the effects of alcohol intoxication. Staff assess the health and social needs of individuals and make referrals to appropriate community resources upon discharge from the program. Referrals are principally from local law enforcement agencies, followed by the EPS and/or the Emergency Department (ED), and individuals who voluntarily enter the program.

Both programs serve the community and provide alternative services to incarceration. Individuals that are provided housing are either affected by a mental health crisis or have relapsed to alcohol use that can negatively affect their permanent housing. These interim

services allow for stabilization and augmented case management services to address the stressors that have resulted in crisis or abuse of alcohol.

Expansion of Walk-In Shelter Beds (Short-Term Needs)

As of April 2019, there were 98 programs with a total unit capacity of 1,742. Over the past year, these programs have collectively served almost 7,500 individuals.

Inclement weather utilization increased from 27% to 44% over the past year. This increase is due to improved coordination with partners such as the National Weather Service, 211, Alert SCC, and the City of San Jose. In addition, through increased outreach and advanced inclement weather episode notification to homeless individuals; there was an enhanced awareness of the availability of beds that resulted in higher utilization. The majority of individuals and families accessing shelter and transitional programs are assessed at entry. The assessment provides information about the level of need for the household, as well as adds the household to the community queue for housing programs. During this reporting period, the individuals enrolled in the shelter and transitional programs had the following characteristics:

- Forty percent (40%) of shelter participants and 23% of transitional participants were assessed in the Permanent Supportive Housing range, indicating they may need permanent assistance to obtain and retain stable housing. Thirty-six percent (36%) of shelter participants and 43% of transitional participants were assessed at the Rapid Rehousing level, indicating a need for time-limited assistance to obtain and retain housing. The number of participants assessed at these levels far exceeds the resources available to serve all participants accessing either program.
- Participants of both shelter and transitional programs indicated a significant number of challenges related to personal wellness, demonstrating a need to address a wide range of issues to increase the participants' ability to obtain and maintain stable housing. This includes 51% of shelter participants and 25% of transitional participants reporting abuse or trauma and 27% of shelter participants and 12% of transitional participants reported a mental health issue or concern.
- Approximately a quarter (23%) of participants leaving shelter and half (48%) of the participants leaving Transitional Housing are exiting to a permanent destination. Until additional housing programs are available to serve participants (as they leave either of these programs), this percentage will likely remain stable.

New Adult Residential Treatment Program

The Department is implementing a new Adult Residential Treatment (ART) program designed for individuals who can take part in programs in the general community, but who without the supportive counseling in a therapeutic setting would be at risk of hospitalization. Without the long-term unlocked residential treatment, these individuals are more likely to be hospitalized. The ART program's goal is to provide a structured recovery-oriented residential setting that assists consumers to improve life skills and reduce functional impairments. The ART will serve individuals diagnosed with SMI and substance use disorders. The program is expected to engage adults and older adults with complex risk factors that include violence, homelessness, neglect, justice-involved and those exposed to trauma.

The ART RFP was released on November 20, 2019, with the intent of selecting one or more vendors by May 12, 2020 with an estimated contract start date on July 1, 2020. The RFP is requesting proposals that can provide both direct services and manage facility needs.

Measures to Increase and Prevent Decline of Board and Care Homes and Beds

The AOA System of Care is working with the OSH and Facilities and Fleet (FAF) to purchase board and care homes that have plans to close and go out of business. To support potential purchase(s) for the SMI/co-occurring population, the Department included the County's maximum allowable Mental Health Services Act (MHSA) funding ($8 million) in the MHSA Plan Update to purchase and operate residential care facilities; this funding can be used for up to ten (10) years. By purchasing and preventing the closure of these homes, the intention is to mitigate the displacement of consumers currently living in these homes and abate further homelessness.

In addition, the Department recently received the Los Angeles County Mental Health Department (LADMH) report on stabilizing board and care facilities, recognizing the critical importance of maintaining and increasing these facilities. This report was approved by the Los Angeles County Board of Supervisors on November 12, 2019 and the Department, with OSH, plans to follow up with the LADMH team in December 2019.

In an effort to increase and prevent the decline of the board and care homes and beds, the AOA System of Care Division Director convenes a quarterly stakeholder meeting with the State Community Care Licensing staff and the Public Guardian Office. This meeting is used to collaborate and discuss ways to provide on-going support for existing board and care facilities that are struggling to maintain their licensure due to several deficiencies in their facility.

Hospital Discharge Transition Treatment Team

The Department continues to work on reducing the use of inpatient psychiatric hospital services for individuals diagnosed with serious mental illness. The readmission rate measures the unplanned readmissions of individuals who have been discharged from acute psychiatric

hospitals within the past 30 days. The AOA Hospital Liaison implemented a practice management solution to improve data captured at the Barbara Aarons Pavilion (BAP) and contract hospitals to allow for more efficient intervention.

To address the readmission rate, a pilot project using an Inpatient Liaison was instituted at the BAP in 2017, with the aim to provide care coordination for patients discharging from the hospital. Care coordination has improved for consumers transitioning from inpatient hospitals back into the community. In addition, the Inpatient Liaison has improved relationships with the Outpatient Treatment Team service providers and inpatient providers by instituting quarterly meetings with the inpatient and outpatient providers to discuss challenging issues that affect clients. Another area of improvement is the Inpatient Liaison's ability to flag consumers with two hospitalizations, through early identification and proactive case management of these high-risk patients, thereby reducing readmissions. The AOA System continues to track the monthly readmission rate, which is currently 10.7 %, a slight increase in the readmission rate due to several high-need, high acuity clients waiting for state hospital beds.

New Step Down Service Option to Support Wellness and Recovery

The new Wellness and Recovery Medication Services (WARMS) was initially piloted in County-operated mental health clinics and has been fully implemented at the Downtown Mental Health and Narvaez Clinics. WARMS was developed to support adult outpatient clients in maintaining their level of wellness with case management, peer support and medication support that is provided every 4-12 weeks from a psychiatrist and licensed psychiatric technician. For this lower level of care, clients continue to receive: 1) an annual mental health assessment, 2) ongoing treatment planning, and 3) light touch case management. In the past fiscal year, mental health contract providers communicated their interest in implementing WARMS to support their outpatient level of care. Currently, there are six (6) contract providers utilizing this option, and in the next fiscal year, the program will be expanded to all AOA outpatient providers.

Exploration of Medical-Detoxification Services (MHTC)

The MHTC is a service benefit covered under the Drug Medi-Cal Organized Delivery System Waiver (DMC-ODS). This would not be a "center," but rather a medical service provided in a hospital setting. The Department is working with Valley Medical Center leadership to explore implementation of an MHTC service that would provide medical detoxification and supportive treatment for clients. The intervention addresses severe addiction to drugs and/or alcohol that requires medical supervision as the individual detoxes from the substance. For individuals who are severely addicted to alcohol and other drugs, such as benzodiazepines, detoxification can be life-threatening during the early stages of detoxification. This is further exacerbated when an individual also has a chronic health condition that can further complicate the detoxification process.

To manage detoxification in these circumstances, medical interventions (including the administering of medication to minimize the deleterious effects of the detoxification process) are required. The services offered through SUTS are routinely provided to individuals that are homeless, involved with the criminal justice system, and have co-occurring mental health symptoms. These augmented services would effectively address and stabilize individuals with acute addiction issues who are involved with all system partners that also serve this population.

Enhanced Lanterman-Petris-Short (LPS) Act Conservatorship

Mental health conservatorships, also known as LPS conservatorships, are established to provide mental health services for Santa Clara County residents who are gravely disabled (unable to provide for their food, clothing or shelter) due to serious mental illness. These individuals have been found by the Court unable or unwilling to accept voluntary treatment. Mental health conservatorships are also known as Lanternam-Petris-Short conservatorships or "LPS", named after the state Assemblyman and Senators who wrote the legislation. The law went into effect in 1972. This procedure is established in the California Welfare and Institutions Code (WIC).

Mental health conservatorship is a legal procedure through which the Superior Court appoints a conservator of the person to authorize psychiatric treatment, including the use of psychotropic medications and placement in a locked facility. The conservatee must meet the narrow definition of grave disability due to a serious mental disease.

LPS conservatorships may only be initiated by a psychiatrist while a client is in an acute psychiatric setting. Only psychiatric facilities (including jail psychiatry), may make referrals for conservatorships. Clinicians have discretion about when to refer; the treating physician may choose not to refer if it is believed that a client will recover before the hold expires. If a person reaches the 17-day limit for a hospital hold, they must be released unless a conservatorship is in place.

LPS conservatorships start with a 72-hour psychiatric hold (also known as a Welfare and Institution Code (WIC) Section 5150 hold). If clients continue to be considered gravely disabled and need additional intensive treatment, a psychiatric clinician may file for a 14-day hold (WIC Section 5250 hold). Under these WIC provisions, a patient can be held for a maximum of 17 days without conservatorship. After the first three days, the client has the right to a hearing and representation by the Public Defender.

Upon receiving a referral, the Public Guardian Conservator will determine if the referral is appropriate (that the client is a Santa Clara County resident and is on an involuntary hospital hold). If deemed appropriate, the Public Guardian Conservator works with County Counsel to petition the Superior court to grant a temporary conservatorship (T-con). This ensures that

the client will continue to receive appropriate care during the judicial process. Once the T-con is granted, the Public Conservator completes an investigation, including consulting with the psychiatrist, reviewing medical records and meeting with family (if appropriate). The Public Guardian Conservator then works with County Counsel to file a petition with the Court for continued conservatorship. If the T-con expires before the petition is ready, the Court may grant a 30-day extension.

Proposed conservatees are appointed representation by an attorney from the Office of the Public Defender. If the Court determines that the client is gravely disabled due to serious mental illness and are unable or unwilling to accept voluntary treatment, the client is placed on a "permanent" conservatorship, which lasts up to one year. The client has a right to appeal the conservatorship and may request a trial.

The Public Guardian Conservator works with the Department's 24-Hour Care team to place the client in treatment, which generally includes finding an appropriate residential facility based on the physician's recommendation and the needs of the client. The Public Guardian Conservator:

- Prepares reports for the Court
- Recommends appropriate level of placement, seeking the best and most independent living environment available, within the conservatee's abilities and resources
- Monitors psychiatric care in collaboration with treatment team
- Consents to medical treatment and psychiatric medications when authorized
- Advocates on behalf of conservatees
- Provides case management for clients

A general LPS conservatorship lasts for a year or until it is determined that the conservatee no longer meets the legal criteria for conservatorship. At the end of the year, if the conservatee continues to meet the criteria for conservatorship, County Counsel files a petition for renewal of conservatorship.

Implementation of Assisted Outpatient Treatment (AOT)

In 2002, California passed The Assisted Outpatient Treatment Demonstration Project Act, aka Laura's Law, authorizing the provision of assisted outpatient treatment (AOT). As explained in reports to the Health and Hospital Committee (HHC) on September 13, 2017 (ID# 88121) and August 22, 2019 (ID# 97937),[1] this law allows courts, in certain circumstances after following a specific set of procedures, to order people to receive

[1] These reports are attached to this report for ease of reference.

involuntary outpatient mental health services.[2] The 2002 law did not provide any funding for implementing AOT[3] and specifies that funding for voluntary mental health programs may not be reduced as a result of the implementation of AOT. Each County Board of Supervisors must approve AOT implementation in its county.

Currently, 20 counties have implemented AOT and are able to use the court system to enroll in involuntary outpatient treatment people with serious mental illness who are unable and/or unwilling to participate in treatment and meet the criteria established in Welfare & Institutions Code § 5346. As part of the AOT process, before AOT proceedings can begin, the person must have been offered an opportunity to participate in a treatment plan and continue to fail to engage in treatment. So far, the vast majority of people involved in an AOT program voluntarily engaged with services before court proceedings began.

The most recent information available about the outcomes of those 20 AOT programs is derived from data six counties provided[4] to the California Department of Health Care Services (DHCS) for the 2016-2017[5] time period. During that time period, there were 63 court-involved individuals in the six reporting counties. All of the data collected indicates that those 63 people benefited from being connected to treatment via AOT: homelessness, hospitalization, and contact with law enforcement decreased; some people secured employment; and most individuals remained fully engaged with services at the end of their court ordered treatment. However, none of the reports used standardized measures, followed participants for a standard period of time, included a large enough sample size, or compared the AOT participants to a control group that did not face the threat of court order to enter treatment. Given these limitations, the utility of this outcome data is quite limited and cannot demonstrate a causal relationship between the AOT process and the outcomes for the participants.[6]

As detailed in other sections of this report, Santa Clara County recently stood up new FACT, ACT, and FSP services. These services use evidence-based practices to provide the level of care most AOT participants would require, using a "whatever it takes" approach. The Department has also been making efforts to expand the breadth and methods of its community engagement. AOT participants have the option of engaging Mobile Crisis Response Team, In-Home Treatment program, Crisis Text Line, Homeless Mentally Ill Outreach and Treatment program, and call center. With the recent expansion of services and

---

[2] Please see the September 13, 2017 report for more detailed description of the goals of AOT (packet pages 585-86), eligibility criteria (586-87), court process (587), and service program requirements (588).
[3] Orange County and Nevada County estimated treatment costs at $35,000-$40,000 per person per year.
[4] The other counties did not have enough data to report.
[5] Most of the counties currently using AOT, did not begin implementation until 2015-2016.
[6] San Francisco and Contra Costa Counties have also released evaluation reports on their AOT implementation. These counties reported similar findings and the utility of their data is similarly limited.

continued efforts at voluntary engagement, the Department is already providing many of the beneficial pieces associated with AOT in Santa Clara County.

At the August 22, 2019 HHC meeting, Supervisors Ellenberg and Simitian asked the Department to provide the HHC with quarterly reports on the progress of these new services and include in those reports an analysis of the possibility of implementing an AOT program. Given how new the ACT, FACT, and FSP services are to the County, these reports will allow the HHC to keep a close eye on their implementation and gauge their effectiveness.

The recommended action supports the County of Santa Clara Health System's Strategic Road Map goals by increasing the number of healthy life years through improving access to safe, supportive, and effective care.

CHILD IMPACT

The recommended action would have a positive impact on children by providing information on projects and resources for homeless, dually diagnosed, and severely mentally ill clients from this target population.

SENIOR IMPACT

The recommended action would have a positive impact on seniors by providing information on projects and resources for homeless, dually diagnosed, and severely mentally ill clients from this target population.

SUSTAINABILITY IMPLICATIONS

The recommended action balances public policy and program interests and enhances the Board of Supervisors' sustainability goals of social equity and safety by outlining and developing processes and procedures to address the needs and engage homeless individuals, dually diagnosed and SMI individuals in Santa Clara County.

BACKGROUND

At the August 22, 2019 HHC, the Department provided information on the Fiscal Year (FY) 2019 Work Plan and accomplishments, including expansion of the AOA System's crisis continuum, diversion and post justice services and planned implementation of new and expanded services (ID# 97937). These services include Assertive Community Treatment, Forensic Assertive Community Treatment, Intensive Full-Service Partnerships and the In-Home Outreach Teams. In addition, the Blackbird House, a new Peer Respite program operated by Caminar, opened its door in December 2018. The Department also reviewed the FY2020 Work Plan (ID# 97937) which includes new services in both County-operated programs and RFPs for new contract provider services. These services were designed to meet the needs of clients with intensive mental health and substance use issues.

CONSEQUENCES OF NEGATIVE ACTION

Failure to approve recommended action would result in the inability of the Board of Supervisors to receive a report on the current and future projects, plans, and services that would help engage house, and serve homeless, dually diagnosed, and SMI individuals.

LINKS:

- Linked To: 98761 : 98761
- Linked To: 88121 : 88121
- Linked To: 97937 : 97937