Alameda County In-Home Outreach Team, Assisted Outpatient Treatment, and Community Conservatorship
Nine Month Interim Evaluation

Prepared by:

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# Table of Contents

IHOT, AOT, and CC Overview ........................................................................................................... 1

In-Home Outreach Team (IHOT) Program ....................................................................................... 1

Assisted Outpatient Treatment (AOT) Program ............................................................................. 2

Community Conservatorship Program .......................................................................................... 3

IHOT, AOT, and CC Implementation ............................................................................................... 4

Methods ........................................................................................................................................ 6

Outreach and Engagement ............................................................................................................. 6

IHOT Consumer Profile .................................................................................................................. 10

IHOT Consumer Outcomes ............................................................................................................ 11

Psychiatric Hospitalizations and Crisis Episodes ............................................................................ 12

Criminal Justice Involvement ......................................................................................................... 13

Homelessness ................................................................................................................................ 13

Service Connectedness .................................................................................................................. 13

Court-Involved Programs ............................................................................................................... 14

Summary ........................................................................................................................................ 16

Appendix I. Assisted Outpatient and Community Conservatorship Eligibility .............................. 18

Appendix II. Overview of Full Service Partnership Service Goals and the Full Spectrum of Community Services ........................................................................................................... 19
Table of Figures

Figure 1. Implementation Timeline................................................................................................................4
Figure 2. Overview of IHOT, AOT, and CC Implementation.............................................................................5
Figure 3. IHOT Referral Sources (N = 171) .......................................................................................................7
Figure 4. Outcome of Each Outreach and Engagement Attempt with Consumers (N = 1,367) .................8
Figure 5. IHOT Social Services and Supports Referrals .......................................................................................9
Figure 6. Service Engagement after IHOT Enrollment (n = 27) ......................................................................14
Table of Tables

Table 1. IHOT, AOT, and CC Community-Based Providers ............................................................. 2
Table 2. IHOT Consumers per Provider ............................................................................................. 7
Table 3. Demographics of Consumers Connected to IHOT (N = 139) ................................................. 10
Table 4. IHOT Consumer Primary Diagnoses (N = 139) .................................................................. 10
Table 5. Summary of IHOT Enrollment Length .................................................................................. 11
Table 6. IHOT Consumers’ Crisis Episodes Before and During IHOT ................................................ 12
Table 7. IHOT Consumers’ Psychiatric Hospitalizations Before and During IHOT ............................ 12
Table 8. Summary of Consumers’ Service Connections after IHOT Enrollment (n = 63) .................. 14
Table 9. Amount of Time from IHOT Enrollment to AOT Enrollment .............................................. 15
IHOT, AOT, and CC Overview

In 2002, the California legislature passed California Assembly Bill 1421 (AB 1421; also known as “Laura’s Law”) to authorize the provision of Assisted Outpatient Treatment (AOT) with the goal of breaking the cycle of repetitive psychiatric crises and resulting hospitalizations, incarcerations, and homelessness of the most seriously mentally ill consumers in California who struggle to engage in services. AOT aims to change the mental health system by:

1. Allowing “qualified requestors”\(^1\) to refer individuals who appear to meet AOT eligibility criteria to AOT;
2. Requiring assertive outreach to engage individuals into outpatient mental health services; and
3. Utilizing civil court involvement to compel and supervise participation in outpatient mental health services.

On February 25, 2014, the Alameda County Board of Supervisors conducted a hearing on AB 1421. Under the Board’s direction, Alameda County Behavioral Health Care Services (ACBHCS) initiated a stakeholder planning process to explore and identify programs and services to meet the mental health needs of the County’s AB 1421 target population, with the goals of reducing or avoiding unnecessary hospitalizations, incarcerations, and homelessness and increasing consumers’ engagement in mental health treatment. The County formed a stakeholder workgroup of representatives from the County’s Social Services Agency, Sheriff’s Office, Public Defender’s Office, and ACBHCS; consumers; family members; and service providers. This workgroup was tasked with reviewing possible programs and services that would meet the needs of the County’s AB 1421 target population. Recommendations from this workgroup included the development of In-Home Outreach Teams (IHOT) based on San Diego’s model, as well as a 12-person Community Conservatorship (CC) pilot program based on San Francisco’s model, both of which were approved by the Board of Supervisors. On November 17, 2015, the Board also approved a five-person AOT pilot project. Both the AOT and CC programs are 12-month pilots, and all three programs were launched in July 2016. The following section provides an overview of each program.

In-Home Outreach Team (IHOT) Program

The IHOT program is an outreach and engagement initiative based on a model originally designed in San Diego and funded by Mental Health Services Act (MHSA) Innovation funds. It provides “intensive outreach and engagement, mental health screening, in-home intervention, family education, and support and linkage to treatment” for individuals who are not voluntarily engaging in services.\(^2\) Data from the San Diego program indicate a trend towards reduced use of psychiatric emergency services and increased use

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\(^1\) Qualified requestors include: An adult who lives with the individual; Parent, spouse, adult sibling, or adult child of the individual; Director of an institution or facility where the individual resides; Director of the hospital where the person is hospitalized; Treating or supervising mental health provider; Probation, parole, or peace officer.

of ongoing outpatient mental health treatment among individuals who are referred to and engaged in IHOT services, as compared to before IHOT engagement.³

In Alameda County’s IHOT program, consumers are identified and referred through the ACBHCS Access phone line, psychiatric inpatient care, and the ACBHCS High Utilizers list. Each IHOT provider employs culturally relevant and age-specific mobile outreach strategies to build trust and rapport with referred individuals and their families, in order to connect them to voluntary specialty mental health services. If at any time during the IHOT outreach and engagement process individuals are not engaging in voluntary services and appear to meet AOT eligibility criteria, IHOT providers may refer them to AOT.

Alameda County’s IHOT program is contracted to four community-based providers, each of which has a specific cultural and/or geographic focus, as shown in Table 1.

| Table 1. IHOT, AOT, and CC Community-Based Providers |
|----------------------------------|----------------------------------|
| **Provider** | **Populations** | **Geographic Area** |
| Abode | Adults | South and East County |
| Bonita House | Adults | Oakland  
 |  | | North and Central County |
| La Familia | Adults  
 | | Latino Adults | Oakland  
 |  | | North and Central County |
| Stars | TAY | All County |

**Assisted Outpatient Treatment (AOT) Program**

Assisted Outpatient Treatment (AOT) refers to a legal process by which a judge may compel a person with serious mental illness who meets the AOT eligibility criteria articulated in the California Welfare & Institutions Code⁴ (WIC) (see Appendix I for AOT eligibility criteria) to comply with a treatment plan on an outpatient basis. The WIC also mandates that the treatment plan for AOT consumers consists of a Full Spectrum of Community Services, as included in a Full Service Partnership (FSP). Such services are typically wraparound services with a low staff-to-consumer ratio (1:10), and employ a “whatever it takes” approach to supporting consumers.⁵ Appendix II provides an overview of the goals and services of an FSP program.

When a person is referred to AOT and appears to meet eligibility criteria at the initial screening, they have the option to participate in services on a voluntary basis, including outreach and engagement from an IHOT program. If an individual appears to meet criteria for AOT but refuses voluntary services, including refusal to engage with the IHOT program, a licensed psychologist conducts a psychological assessment and investigation to confirm that the consumer does in fact meet AOT criteria. The psychologist then completes and submits an affidavit to County Counsel for review. Once County Counsel has reviewed the affidavit, they provide the mental health director or designee with a copy of the petition for review and


⁴ Section 5346, Welfare and Institutions Code

⁵ Welfare and Institutions Code, Section 5348
signature. If approved, County Counsel files the petition in Superior Court. Once the court petition is filed, the consumer is appointed a public defender who confers with the consumer about whether to accept services voluntarily or contest the petition. If the consumer agrees to accept services during the first court appearance, they sign a voluntary settlement agreement with the court agreeing to participate in the treatment plan for six months. If the consumer contests the petition, the court proceeds with a hearing where testimony is received from both the psychologist and the consumer. Based on the evidence presented, the court determines if AOT should be ordered for a period of up to six months. Those who enter an agreement with the court — either via settlement agreement or via court order — enroll in the AOT FSP program and receive services from Telecare’s FSP team.

Community Conservatorship Program

Based on the Community Independence Pilot Project (CIPP) in San Francisco, Community Conservatorship (CC) in Alameda County allows hospitalized individuals to voluntarily opt into a Lanterman-Petris-Short (LPS) Act conservatorship, which becomes mandatory once the conservatorship is established. LPS conservatorship is intended to “provide individualized treatment, supervision, and placement.” CC is intended to minimize the time spent in sub-acute and other locked psychiatric facilities for individuals who can safely receive treatment in the community with the support and oversight of the Public Guardian-Conservator.

As originally designed, the CC model in Alameda County specifies that a hospitalized individual is referred by a hospital psychiatrist and, following referral, is vetted by Public Guardian-Conservator, the Public Defender, and BHCS, with consultation from County Counsel. If deemed appropriate for CC, the individual is referred to the court for a conservatorship hearing. During this process, ACBHCS staff, in collaboration with the treating facility and the Public Guardian-Conservator, identify appropriate services for each eligible individual, including FSP services, and attempt to engage them in these ongoing services. As implementation progressed, the MOU was amended twice, first in November 2016 and again in March 2017, in order to expand the target population criteria and to allow for referrals from sub-acute facilities, as well as from multiple inpatient psychiatric facilities. These amendments allow for referral flexibility and allow for the county to reach a greater number of potential participants who are at high risk.

Like AOT, CC mental health services are delivered by a Telecare FSP team that provides intensive individualized behavioral health and social services in the least restrictive environment suitable, available, and necessary. Individuals under CC live in the community, either in a Board and Care facility or in a supervised family home. Compared to those under traditional LPS conservatorships, individuals under CC in Alameda County are intended to be stepped down more quickly from inpatient settings with intensive services and increased oversight.

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6 Section 5001, Welfare and Institutions Code
7 LPS conservatorship can also apply to individuals with chronic alcoholism or developmental disabilities. For the purposes of this report, only language regarding mental illness is included.
IHOT, AOT, and CC Implementation

Together IHOT, AOT, and CC provide a comprehensive approach to outreach, engagement, and civil court involvement to identify, engage, and retain individuals who are not voluntarily participating in long-term specialty mental health services. The County’s approach seeks to engage consumers in order to:

- Promote recovery and increased quality of life;
- Decrease hospitalization, incarceration, and homelessness; and
- Increase life skills, access to benefits and income, involvement with meaningful activities such as education and employment, and socialization and psychosocial supports.

Following the Board of Supervisors’ approval of AOT in November 2015, ACBHCS and other County stakeholders had six months to prepare for implementation of all three programs. This included conducting a competitive procurement process for both IHOT and FSP services as well as external program evaluation services, and establishing all of the necessary agreements, processes, and protocols between ACBHCS and other participating agencies (e.g. Superior Court, Public Defender, and County Counsel).

In the first three months of the program, IHOT providers began outreach and engagement to individuals referred from the ACBHCS Access phone line and High Utilizers list. The first AOT referral and subsequent AOT enrollment occurred within 2 months. By the end of the first six months of implementation, all programs were serving consumers, and the AOT pilot program was at capacity. As of the nine-month mark, all programs continued to grow their enrollment, with the exception of AOT, which remained at capacity.

**Figure 1. Implementation Timeline**

<table>
<thead>
<tr>
<th>Preparation</th>
<th>Quarter 1 (July- Sept 2016)</th>
<th>Quarter 2 (Oct- Dec 2016)</th>
<th>Quarter 3 (Jan- Mar 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/25/14: BOS approves IHOT &amp; CC</td>
<td>7/8/16: IHOT services begin</td>
<td>12/2/16: First CC Enrollment</td>
<td>3/31/17: 3 CC clients enrolled</td>
</tr>
<tr>
<td>11/17/15: BOS approves AOT</td>
<td>8/24/16: First AOT Referral</td>
<td>12/31/2016: 93 IHOT clients served</td>
<td>3/31/17: 139 IHOT clients served</td>
</tr>
<tr>
<td>6/31/16: Services contracted</td>
<td>9/9/16: First AOT Enrollment</td>
<td>12/31/2016: AOT Program at capacity (5)</td>
<td>3/31/17: AOT Program at capacity (5)</td>
</tr>
</tbody>
</table>

Figure 2 provides a snapshot of the number of consumers referred to and engaged in IHOT and AOT during the first nine months of program implementation. The County received IHOT referrals for 149 unique consumers, 139 of whom were connected to an IHOT provider. Seventy-one consumers were still receiving IHOT services at the conclusion of the evaluation period, while 63 were discharged from IHOT. Twenty-seven consumers who completed IHOT were connected to mental health services, of whom 22 accepted services on a voluntary basis and five were connected through an AOT petition and agreement.
with the court (i.e. voluntary settlement agreement or AOT court order). Eleven of the 63 discharged consumers withdrew, were unavailable, or were discharged without meeting their treatment goals (e.g. IHOT was unable to engage them in services), and 25 discharged from IHOT without being connected to services.

Additionally, during this time there were 24 unique consumers considered for CC, and six consumers were formally referred with a vetting form submitted to the Public Guardian-Conservator from either the John George Psychiatric Hospital (JGPH) or Villa Fairmont Mental Health Rehabilitation Center. Of the six formally referred, three were enrolled, two did not move forward in the CC enrollment process, and 1 was still being considered at the end of the evaluation period.

Figure 2. Overview of IHOT, AOT, and CC Implementation

This interim report summarizes the activities and preliminary outcomes for the first nine months of the IHOT, AOT, and CC programs, and provides recommendations for future program implementation.
Methods

The evaluation period for this interim report spans from July 1, 2016, through March 31, 2017, and captures the first three quarters of program implementation. Quantitative data were collected from a variety of County sources, including the County’s Access phone line, service utilization billing data, and Clinician’s Gateway. Providers tracked each outreach and engagement encounter in an Excel workbook before transitioning to the use of Clinician’s Gateway. At the time of this report, all IHOT providers but one were using Clinician’s Gateway for data entry. All providers also used an Excel workbook to track consumers’ scores on the Self-Sufficiency Matrix (SSM), a standardized instrument that allows providers to evaluate consumers across domains such as housing, income, and education with scores ranging from “in crisis” to “thriving.” FSP forms (i.e., the PAF, KET, and 3M quarterly form) collected from Telecare’s Caminar data system were used to assess justice involvement and the residential status of AOT and CC consumers. Finally, IHOT providers tracked consumers’ self-reported experiences of homelessness, arrest, and incarceration. It should be noted, however, that the self-reported data presents three key limitations in this evaluation:

1. In general, self-reported data can be less reliable than institutional data because consumers may not be willing to disclose experiences without having a strong rapport with the providers;
2. Consumers may not recall information accurately; and
3. In this evaluation, IHOT providers did not consistently collect the self-reported items, likely due to challenges in getting consumers to respond, particularly those who by definition struggle to engage with mental health services.

Another data limitation was the variability in the amount of optional data entered by IHOT providers into Clinician’s Gateway; in many instances the recipient, location, and/or position of the provider could not be determined. Additionally, given the small sample sizes of enrolled consumers and the limitations set forth by the Health Insurance Portability and Accountability Act (HIPAA), groupings of less than 10 individuals are not explicitly reported.

Outreach and Engagement

The County received 171 IHOT referrals from a range of “qualified requestors” and the High Utilizers List.

According to the County’s program model, consumers are referred to IHOT/AOT through the County Access phone line or are identified by the County as high utilizers of psychiatric emergency services. During the first nine months of program implementation, Alameda County received a total of 171 referrals for 149 unique consumers. Of the 171 total referrals, 138 were made through the Access phone line, 29 were from the High Utilizers List, and four were from an undetermined source.

As shown in Figure 3, the majority of referrals were from either family members (34%), mental health service providers (19%), or the High Utilizers list (17%). Additional Access referrals were made by law
enforcement, community-based organizations, Psychiatric Emergency Services (PES)/crisis services, and other individuals in the consumers’ networks.

Figure 3. IHOT Referral Sources (N = 171)

Unlike IHOT or AOT, CC consumers are identified and referred during an inpatient stay. After the initial referral process, the Public Guardian-Conservator, in collaboration with BHCS and the Public Defender’s Office, engage in a vetting process to determine a consumer’s eligibility. Between July 1, 2016 and March 31, 2017, twenty-four consumers were considered for CC, of whom six were formally referred by submitting a vetting form to the Public Guardian-Conservator, and three were enrolled in the CC program.

IHOT engaged 93% of referred consumers from the target population.

Of the 149 unique consumers referred to IHOT, **139 were connected to an IHOT provider and received IHOT services.** In the first nine months of IHOT, each provider agency served between 21 and 47 consumers. Table 2 presents a breakdown of consumers served by each IHOT program. Differences in the number of consumers served across providers reflect the specific populations each agency serves as well as staggered start dates.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Total Number of Consumers Served&lt;sup&gt;9&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abode</td>
<td>43</td>
</tr>
<tr>
<td>Bonita House</td>
<td>47</td>
</tr>
<tr>
<td>La Familia</td>
<td>40</td>
</tr>
<tr>
<td>Stars</td>
<td>21</td>
</tr>
</tbody>
</table>

<sup>8</sup> Twelve consumers received services from more than one provider, several of whom transitioned from Abode to Bonita House when Bonita House began accepting consumers in September; therefore, the total number of consumers served in Table 2 exceeds 139.

<sup>9</sup> Some consumers were served by more than one IHOT provider.
Engaging consumers requires many attempts of assertive and persistent outreach with consumers, their families, and other natural supports, in diverse settings, by interdisciplinary teams.

Once IHOT providers receive a referral, the team begins an intensive outreach and engagement process with the consumer, the consumer’s family, and others in the consumer’s network. In total, IHOT providers made 3,283 attempts at engagement with the 139 consumers and their support systems (i.e. family members, friends, neighbors, roommates, and other service providers), which suggests that persistent outreach is a key component of IHOT implementation. The teams are engaging individuals “where they’re at” by meeting consumers and other individuals in a variety of locations, including the community, hospitals, shelters, and local clinics, as well as by phone call or text message. Additionally, IHOT programs are conducting outreach attempts using interdisciplinary teams, which include family and peer partners, mental health clinicians, case managers, and IHOT program directors.

IHOT providers’ persistent outreach with consumers promotes ongoing IHOT engagement.

As shown in Figure 4, 54% of outreach attempts to consumers resulted in service engagement or a willingness to participate in ongoing outreach, while consumers were unavailable or did not show for 36% of attempts. Consumers refused 10% of providers’ outreach and engagement attempts.

On average, IHOT providers are spending the most time with consumers (78 minutes) when consumers are engaged. However, providers are also spending an average of 73 minutes with consumers who refuse services and an average of 33 minutes for encounters when consumers did not show or were unavailable, which suggests that even when a consumer is initially unwilling to engage or unavailable, the teams persist with their engagement efforts.

Consumers and their families have access to a variety of social services and supports through their IHOT participation, including linkages to health, housing, and income-related services.

As part of their outreach and engagement efforts, IHOT providers made a variety of referrals to connect consumers and their families to social services and supports. As shown in Figure 5, IHOT providers made most referrals to primary care providers, family support services, or housing and homelessness services. This indicates that they are connecting both consumers and their families to a variety of supportive services, in addition to mental health services. The frequency of primary care and housing and
homelessness service referrals also suggests that, during the 90-day IHOT program window, IHOT providers are prioritizing immediate needs such as physical health, shelter, and benefits over more long-term goals such as education and employment.

Figure 5. IHOT Social Services and Supports Referrals

Throughout their work with consumers, IHOT providers used the Self-Sufficiency Matrix (SSM) to assess consumers’ changes on a wide range of self-sufficiency indicators, such as education, employment, self-care, and social relationships. Consumers’ average scores did not change in the first 60 to 90 days of enrollment. This is likely due to several factors, including that providers are prioritizing immediate needs, such as physical health and housing, and that two to three months of IHOT engagement is not enough time to address such pervasive barriers to self-sufficiency.

IHOT programs were unable to engage all referred consumers, even if consumers initially agreed to work with an IHOT team.

At the time of referral, IHOT programs were able to engage 139 of 149 referrals (93%). However, an additional 11 consumers either withdrew, disappeared, or were discharged before making substantial progress towards their goals, ten of whom were available for continued service engagement (i.e. Alameda County residents). This suggests that these additional 10 consumers did not sustain engagement with IHOT long enough to experience benefits or become connected to ongoing mental health services. Combined, this means that there up to 20 individuals (14%) who may be unable and/or unwilling to engage with IHOT and may require additional types of supports or interventions to address their mental health needs, such as court involvement.
IHOT Consumer Profile

IHOT programs are reaching their identified target population.

Table 3 summarizes the demographic characteristics of the 139 consumers connected to an IHOT provider. The majority were male (66%) and either Black/African American (33%) or White (31%). Most were between the ages of 30 and 39 (26%) or 50 and older (24%).

<table>
<thead>
<tr>
<th>Category</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>66%</td>
</tr>
<tr>
<td>Female</td>
<td>24%</td>
</tr>
<tr>
<td>Unavailable or Unknown</td>
<td>10%</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Black/African American</td>
<td>33%</td>
</tr>
<tr>
<td>White</td>
<td>31%</td>
</tr>
<tr>
<td>Unavailable or Unknown</td>
<td>15%</td>
</tr>
<tr>
<td>Other (including Latino/Hispanic and Native American)</td>
<td>12%</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>9%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>30-39</td>
<td>26%</td>
</tr>
<tr>
<td>50+</td>
<td>24%</td>
</tr>
<tr>
<td>25-29</td>
<td>17%</td>
</tr>
<tr>
<td>40-49</td>
<td>16%</td>
</tr>
<tr>
<td>Unavailable or Unknown</td>
<td>11%</td>
</tr>
<tr>
<td>19-24</td>
<td>6%</td>
</tr>
</tbody>
</table>

Table 4 shows the primary diagnoses of consumers as recorded when they began receiving IHOT services. Just over half (54%) had a primary diagnosis of schizophrenia or other psychotic disorder and 17% had a mood disorder, which includes bipolar and depressive disorders. Data suggests a low rate of co-occurring substance use disorders, which may be related to substance use not being documented consistently, or to an unexpectedly low occurrence of co-occurring substance use disorders.

<table>
<thead>
<tr>
<th>Primary Diagnosis</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia or other Psychotic Disorder</td>
<td>54%</td>
</tr>
<tr>
<td>Unknown, Unspecified, or Other</td>
<td>29%</td>
</tr>
<tr>
<td>Mood Disorder</td>
<td>17%</td>
</tr>
</tbody>
</table>
IHOT Consumer Outcomes

The following section presents findings on consumer outcomes prior to and during IHOT participation. It is important to note the varied length of consumers’ IHOT enrollment because the time frame for outcomes such as homelessness, arrests, and incarcerations are recorded for the entire year prior to enrollment, and outcomes such as psychiatric hospitalizations and crisis stabilization episodes are recorded for three years prior to enrollment. To account for differences in the pre- and post-IHOT time periods, findings are standardized to rates per 180 days, which allows for more reliable comparisons of outcomes. Nevertheless, because consumers have spent much less time in IHOT compared to their pre-enrollment periods, there is less opportunity for them to experience outcomes such as hospitalization, homelessness, arrest, and/or incarceration and, when they do have those experiences, the average rates are slightly inflated by the shorter window of time.

Consumers are enrolled in IHOT for longer than originally planned.

On average, consumers were enrolled in IHOT for 102 days, with participation ranging from just one day to 273 days through March 31, 2017. Most consumers (52%, n = 72) were enrolled in IHOT for more than 90 days (see Table 5).

Table 5. Summary of IHOT Enrollment Length

<table>
<thead>
<tr>
<th>Length of Enrollment</th>
<th>Consumers</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30 days</td>
<td>17% (n = 23)</td>
</tr>
<tr>
<td>30 – 59 days</td>
<td>12% (n = 16)</td>
</tr>
<tr>
<td>60 – 89 days</td>
<td>16% (n = 22)</td>
</tr>
<tr>
<td>90 + days</td>
<td>52% (n = 72)</td>
</tr>
<tr>
<td>Unable to determine</td>
<td>4% (n = 6)</td>
</tr>
</tbody>
</table>

Given that IHOT is intended to provide a 90-day period of outreach and engagement, implementation data suggest that the majority of consumers are participating for longer than expected. While it is not possible to know definitively the factors influencing a longer period of engagement, it may be attributed to some or all of the following:

1. IHOT consumers may be more difficult to engage and require a longer period of engagement.
2. A portion of IHOT consumers may be willing to engage with IHOT programs but may not be ready or willing to voluntarily accept ongoing mental health services. Without a court-involved mechanism to compel participation in mental health services, such as AOT, IHOT providers may be serving people for longer than anticipated.
3. Providers may not be consistently entering administrative discharge paperwork in a timely manner, thereby artificially increasing the length of IHOT enrollment.
Psychiatric Hospitalizations and Crisis Episodes

Fewer consumers experienced psychiatric hospitalization and crisis during IHOT enrollment. For those consumers requiring crisis stabilization and hospitalization, the number of crisis and hospital episodes and length of stay increased.

**About two-thirds of consumers (67%, n = 93) experienced at least one crisis stabilization episode prior to IHOT enrollment.** Consumers with at least one stay in a crisis stabilization facility before IHOT (n = 93, 67%) averaged just under five episodes for every six months, with episodes lasting an average of two days. **About one-third of consumers (31%) experienced a crisis episode during their IHOT enrollment.** The 43 consumers (31%) with a crisis stay during IHOT had about six episodes for every six months that lasted, on average, two days (see Table 6).

<table>
<thead>
<tr>
<th>Crisis Stabilization</th>
<th>Pre-IHOT Enrollment</th>
<th>During IHOT Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Consumers</td>
<td>n = 93</td>
<td>n = 43</td>
</tr>
<tr>
<td>Number of Episodes</td>
<td>4.8 episodes per 180 days</td>
<td>6.2 episodes per 180 days</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>2 days</td>
<td>2 days</td>
</tr>
</tbody>
</table>

**Table 6. IHOT Consumers’ Crisis Episodes Before and During IHOT**

Just over half (56%, n = 78) of all IHOT consumers were hospitalized at least once in the three years before engaging with an IHOT provider. Consumers with at least one psychiatric hospitalization before IHOT (56%, n = 78) experienced about one episode for every six months. On average, episodes lasted about 9.5 days. **A total of 28 consumers (20%) were hospitalized during their IHOT enrollment.** Consumers who were hospitalized during IHOT (20%, n = 28) experienced about two episodes for every six months. On average, these episodes lasted about 11.7 days (see Table 7).

<table>
<thead>
<tr>
<th>Psychiatric Hospitalization</th>
<th>Pre IHOT Enrollment</th>
<th>During IHOT Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Consumers</td>
<td>n=78</td>
<td>n=28</td>
</tr>
<tr>
<td>Number of Episodes</td>
<td>1.3 episodes per 180 days</td>
<td>1.9 episodes per 180 days</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>9.5 days</td>
<td>11.7 days</td>
</tr>
</tbody>
</table>

**Table 7. IHOT Consumers’ Psychiatric Hospitalizations Before and During IHOT**

A small group of consumers were hospitalized shortly after IHOT enrollment and did not meaningfully engage in IHOT services; therefore, they were excluded from the above analysis. For this group, it is likely that they had intense service needs which became apparent with IHOT involvement and resulted in IHOT staff helping individuals to access a higher level of care necessary to remain safe.

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10 Crisis facilities in this analysis include John George Psychiatric Pavilion, Sausal Creek Outpatient Stabilization Clinic, and Willow Rock Crisis Stabilization Unit.
Criminal Justice Involvement

Consumers referred to IHOT experienced low levels of criminal justice involvement, which remained consistently low during program participation.

Upon beginning participation in the IHOT program, consumers were asked to report on their criminal justice system involvement, including the number of times they were arrested and incarcerated in the 12 months before enrollment. Thirty-one consumers provided information on their arrests before and during IHOT. Of the 31 consumers who provided data, approximately half (48%) reported no involvement with the criminal justice system. Fewer consumers (n = 24) provided information on their time spent in jail in the 12 months before during the IHOT program. Of the 24 consumers who provided information on both time points, most (63%, n = 15) were never in jail, either before or during IHOT.

Homelessness

There was little change in the housing status of IHOT consumers during their participation in the IHOT program.

Each consumer was also asked about their experiences of homelessness in the 12 months before beginning the IHOT program and during program participation. As with justice involvement, less than half of consumers provided information for both of these time points. Of the 24 consumers who provided information on their housing status both before and during IHOT, the majority experienced no changes in their housing status from the 12 months before IHOT to their time in IHOT. However, one of the primary referrals for IHOT consumers was to housing and homelessness service providers, which suggests that IHOT consumers were receiving support to address their housing needs during IHOT participation.

Service Connectedness

Several consumers were connected with mental health services after enrolling in IHOT.

A primary goal of IHOT is to connect consumers who are unwilling and/or unable to engage in mental health services with needed mental health services, such as a Full Service Partnership (FSP), service teams, outpatient, day treatment, or residential treatment. According to County service data, of the 63 consumers discharged from IHOT, 27 consumers were connected to mental health services following their participation with IHOT; five of the 27 consumers required court involvement through AOT to participate in these services. As shown in Figure 6, most consumers were connected to either outpatient or day treatment, while the fewest number of consumers were engaged in residential treatment.
Table 8 provides a summary of the levels of service connection for all IHOT consumers after enrolling in IHOT.

<table>
<thead>
<tr>
<th>Level of Engagement</th>
<th>Consumers</th>
<th>Summary of Engagement</th>
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</table>
| Discharged with Meaningful Service Connection | 27% (n = 17) | • At least three days of outpatient or day treatment  
• At least three consecutive residential treatment days  
• At least three services from FSP or service teams |
| Discharged with Some Service Connection | 16% (n = 10) | • One to two days of outpatient, day, or residential treatment  
• One to two services from FSP or service teams |
| Discharged with No Service Connection | 57% (n = 36) | • No connections to outpatient, day, residential, FSP, or service teams |

Among the 27 who were connected, the majority (63%, n = 17) engaged in services in a meaningful way. For those with some service connection, this may represent a new treatment relationship or suggest that the consumer may not be actively participating as agreed.

**Court-Involved Programs**

At the conclusion of the first nine months of IHOT, AOT, and CC implementation, five consumers were enrolled in AOT and three consumers were enrolled in CC. This section provides an overview of consumer outcomes before enrolling in these programs. In order to protect consumers’ privacy, information on their outcomes following IHOT enrollment will be included in future reports when the number of enrolled consumers is greater than ten.
After nine months, AOT is at capacity and CC has improved its ability to receive and vet referrals.

During the first nine months of program implementation, six consumers were referred from IHOT to AOT. Of those six, five were enrolled in AOT. On average, it took approximately five months from IHOT engagement to AOT enrollment. Table 9 describes the time it took from the first attempt at outreach and engagement by an IHOT provider until the person was enrolled in AOT.

<table>
<thead>
<tr>
<th>Table 9. Amount of Time from IHOT Enrollment to AOT Enrollment</th>
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<tbody>
<tr>
<td>Average</td>
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<tr>
<td>153 days</td>
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Twenty-four unique individuals were considered for CC, of which six were formally referred and three enrolled during the first nine months of implementation. During early implementation, the County amended the MOU established at the beginning of the pilot twice to allow CC to expand the target population criteria and to allow for referrals from sub-acute facilities, as well as from multiple inpatient psychiatric facilities.

The court-involved programs are effectively serving the target population.

The eight consumers connected to AOT and CC are representative of the target population for these programs in terms of their history of hospitalization, incarceration, and homelessness. In the 12 months prior to enrollment in one of the court-involved programs, all consumers had stayed in an acute psychiatric hospital or psychiatric health facility, over half had stayed in a long-term institutional care facility, and half were homeless at some point. Less than half had been arrested or in jail. Some additional key findings about the court-involved consumers include:

- All consumers experienced at least one crisis stabilization stay and averaged about seven crisis episodes for every six months. Each stay lasted an average of two days.
- All consumers experienced at least one psychiatric hospitalization and averaged about 2.5 hospitalizations every six months. On average, each hospitalization lasted about two weeks.

The majority of court-involved consumers have experienced dramatic reductions in crisis and hospital episodes and are stably housed, suggesting that AOT and CC are successfully interrupting the cycle of crisis, hospitalization, and homelessness for participating consumers.

All AOT and CC consumers are adhering to court-ordered mental health services.

All AOT and CC consumers received the Full Spectrum of Community Services as outlined in the Mental Health Services Act for Full Service Partnership programs. At the conclusion of the evaluation period, all eight court-involved consumers were consistently adhering to outpatient mental health services, as evidenced by sustained engagement with Telecare’s FSP team.¹¹

¹¹ Treatment adherence is defined as keeping FSP appointments at least one time per week for at least two weeks each month.
Summary

This nine-month interim evaluation of Alameda County’s IHOT, AOT, and CC programs recognizes the efforts of ACBHCS, County Counsel, Public Defender, Public Guardian-Conservator, and community-based organizations in identifying, engaging, and serving consumers who experience psychiatric crisis, hospitalization, and homelessness. The following discussion details the variety of consumer accomplishments and program successes achieved over this nine-month period, and suggests the need for the County to consider additional AOT capacity to effectively meet community needs.

ACBHCS is successfully identifying the target population, and IHOT providers are successfully engaging the majority of consumers.

The IHOT programs were able to initially engage 139 of 149 referrals (93%) and sustain engagement for 128 individuals (86%). Referred individuals came from a variety of sources – including family members, mental health providers, and the ACBHCS High Utilizers list – and had a history of crisis, hospitalization, and homelessness combined with not engaging in ongoing mental health services.

Consumers experience benefits from engaging in IHOT services, including reduced crisis and hospital episodes during IHOT participation, and increased participation in ongoing mental health services following IHOT discharge.

Fewer consumers experienced crisis stabilization and psychiatric hospitalization during IHOT participation, as compared to their history of crisis and hospital episodes before IHOT enrollment. However, for those who did require crisis stabilization or hospitalization, there was a slight increase in number of crisis and hospital episodes as well as a slightly longer length of stay. This suggests that participating in IHOT may have provided many consumers with the support to avoid unnecessary crisis and hospital episodes, and that the consumers who did require crisis stabilization or hospitalization represent unavoidable or necessary emergency interventions.

Almost half (43%) of consumers who successfully discharged from IHOT connected to ongoing mental health services post-IHOT discharge. Of these consumers, 22 accepted mental health services on a voluntary basis and five required a voluntary settlement agreement or AOT court order. This demonstrates that while many discharged IHOT consumers accepted ongoing mental health services on a voluntary basis, a small percentage required court involvement through the AOT program to accept and participate in ongoing mental health services.

The County has modified the CC target population and expanded referral sources to address initial implementation challenges and ensure eligible individuals gain access to the program.

The CC program was amended twice since inception, first in November 2016 and again in March 2017 with the goal of broadening the eligibility criteria in order to reach more potential participants who may benefit from the program. Additionally, the second amendment expanded the referral sources to sub-acute facilities and multiple acute inpatient psychiatric facilities. The Public Guardian-Conservator has begun a training initiative subsequent to the March 2017 amendment in order to provide necessary
training on the CC program to multiple sub-acute and acute facilities throughout the County, with the goal of increased program knowledge ultimately leading to an increase in appropriate referrals.

AOT and CC are meeting their intended objectives, including reduced crisis and hospital episodes, increased stable housing, and adherence with court-ordered mental health services.

Consumers who participated in the FSP program as a result of the AOT or CC programs experienced benefits from their participation. Individuals referred to these programs had higher rates of crisis and hospitalization prior to IHOT enrollment than the larger IHOT consumer group, and experienced a large decrease in crisis and hospital episodes following court-ordered FSP participation. Additionally, the majority of the AOT and CC consumers obtained and/or maintained stable housing and were adherent with court-ordered mental health service participation.

IHOT was not able to engage all referred individuals or connect all IHOT consumers with ongoing mental health services.

While IHOT providers were able to engage the majority of referred individuals, 10 were unable to be engaged at the time of referral, and an additional 10 consumers were available for outreach but did not sustain engagement with the IHOT providers. While it is not possible to draw definitive conclusions, it is likely that at least a portion of these 20 individuals – many of whom have a history of experiencing crisis and hospitalization combined with not participating in ongoing mental health services – would meet criteria for AOT were there additional capacity to serve them.

Thirty-six consumers (57%) discharged from the program without connecting to mental health services. While it is unlikely that all of these 36 individuals would meet criteria for and require AOT, it is likely that some of them would require and benefit from court involvement to participate in ongoing mental health services. Prior to enrolling in IHOT, 18 consumers (50%) had a history of crisis and/or psychiatric hospitalizations similar to the history of the court-involved consumers. ACBHCS may wish to monitor these 18 consumers who were discharged without being connected to mental health services so that they are able to intervene early if they experience additional crisis and/or hospitalization and evaluate their appropriateness for AOT if additional spots become available.

With the AOT program at capacity, IHOT providers can only connect those consumers to mental health services who are willing to accept them on a voluntary basis. While many IHOT consumers accepted voluntary mental health services, IHOT providers have limited or no options for those individuals who are not willing to accept voluntary mental health services and do not meet criteria for an emergency intervention. Given how quickly the AOT program reached capacity, it is likely that additional AOT capacity would improve the ability to connect people to mental health services who are not willing or able to do so on a voluntary basis.
Appendix I. Assisted Outpatient and Community Conservatorship Eligibility

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<thead>
<tr>
<th>Assisted Outpatient Treatment</th>
<th>Community Conservatorship</th>
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<tr>
<td>• The person is 18 years of age or older and suffering from a mental illness.</td>
<td>• Under a Lanterman-Petris-Short (LPS) Act conservatorship a conservator of the person may be appointed for a person who is gravely disabled as a result of a mental health disorder.¹³</td>
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<tr>
<td>• There has been a clinical determination that the person is unlikely to survive safely in the community without supervision.</td>
<td>• Grave disability is defined as a condition in which a person, as a result of a mental health disorder, is unable to provide for his/her basic personal needs for food, clothing, or shelter.</td>
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<td>• The person has a history of lack of compliance with treatment for his or her mental illness, in that at least one of the following is true:</td>
<td>• To be eligible for the Community Conservatorship program a potential participant must meet the definition of grave disability as outlined above and must:</td>
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<tr>
<td>o At least two hospitalizations within the last 36 months, including mental health services in a forensic environment.</td>
<td>• Be an Alameda County resident</td>
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<tr>
<td>o One or more acts of serious and violent behavior toward himself or herself or another, or threats, or attempts to cause serious physical harm to himself or herself or another within the last 48 months.</td>
<td>• Adults who, through clinical assessment, meet LPS criteria for grave disability and could stabilize safety within the community with intensive wrap around services.</td>
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<td>• The person has been offered an opportunity to participate in a treatment plan by the director of the local mental health department, or his or her designee, provided the treatment plan includes all of the services described in Section 5348, and the person continues to fail to engage in treatment.</td>
<td>• Have a history of non compliance with treatment while in the community</td>
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<td>• The person's condition is substantially deteriorating.</td>
<td>• Be hospitalized under a W&amp;I 5250 hold or under a conservatorship.</td>
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<td>• Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure the person's recovery and stability.</td>
<td>• Agree to the administration of psychotropic medication</td>
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<td>• In view of the person's treatment history and current behavior, the person is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to himself or herself, or to others, as defined in Section 5150.</td>
<td>• Agree to readmission to a higher level of care should they decompensate</td>
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<td>• It is likely that the person will benefit from assisted outpatient treatment.</td>
<td>• Agree to waive certain hearing opportunities</td>
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<td>• Additionally, a referral must come from a qualified psychiatrist who has evaluated the client in a locked facility.</td>
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<td>• Not be on active probation, parole or court supervision or be required to register as a 290 registrant.</td>
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¹² Section 5346, Welfare and Institutions Code  
¹³ Section 5350, Welfare and Institutions Code
Appendix II. Overview of Full Service Partnership Service Goals and the Full Spectrum of Community Services

The following are Full Service Partnership (FSP) goals for consumers:

- Live in the most independent, least restrictive housing feasible in the local community.
- Engage in the highest level of work or productive activity appropriate to their abilities and experience.
- Create and maintain a support system consisting of friends, family, and participation in community activities.
- Access an appropriate level of academic education or vocational training.
- Obtain an adequate income.
- Self-manage their illnesses and exert as much control as possible over both the day-to-day and long-term decisions that affect their lives.
- Access necessary physical health care and maintain the best possible physical health.
- Reduce or eliminate serious antisocial or criminal behavior, and thereby reduce or eliminate their contact with the criminal justice system.
- Reduce or eliminate the distress caused by the symptoms of mental illness.
- Have freedom from dangerous addictive substances.

The Full Spectrum of Community Services detailed in the Mental Health Services Act (MHSA) are necessary to attain the goals identified in each person’s Individual Services and Supports Plan (ISSP). The services provided to FSP consumers may also include services that the County, the consumer, and the consumer’s family (when appropriate and as permitted by applicable laws and regulations) deem necessary to address unforeseen circumstances in the consumer’s life that could be but have not yet been included in the ISSP. The Full Spectrum of Community Services that must be available for inclusion in a person’s ISSP consists of the following:

- Behavioral health services and supports including, but not limited to:
  - Behavioral health treatment, including alternative and culturally specific treatments
  - Peer support
  - Supportive services to assist the consumer in obtaining and maintaining employment, housing, and/or education
  - Wellness centers
  - Personal service coordination/case management to assist the consumer with accessing needed medical, educational, social, vocational rehabilitative and/or other community services
  - Needs assessment
  - ISSP development
  - Crisis intervention/stabilization services
  - Family education services
Non-behavioral health services and supports including, but not limited to:

- Food
- Clothing
- Housing including, but not limited to rent subsidies, housing vouchers, house payments, residence in a drug/alcohol rehabilitation program, and transitional and temporary housing
- Cost of health care treatment
- Cost of treatment of co-occurring conditions, such as substance abuse
- Respite care