August 11, 2018

STATEMENT TO BOARD OF SUPERVISORS re August 14th Departmental Agenda Item #7

Supervisors Williams, Hartmann, Wolf, Adam, and Lavagnino,

AOT is a relatively low cost, front end 'prevention' intervention that can greatly reduce the amount of money being directed into high cost, back end services

Our county is now halfway into a Laura's Law pilot program. In this time, the community has gained increasing confidence in the program, due to significant improvement in the health and well-being of 34% of AOT clients who have engaged voluntarily in treatment, receiving assertive outreach by an exceptionally skilled and compassionate AOT staff.

Our county's Stepping Up Initiative has recognized AOT as a key program to divert persons with mental illness from criminalization. At a recent Behavioral Wellness Crisis Action Team meeting, AOT was recognized as a contributing factor in reducing the number of psychiatric holds.

We have reason to celebrate the trajectory of recovery for 34%. However, outcome trends are not encouraging. As of December 2017, 44% of AOT clients had engaged in voluntary treatment. By March 2018, that percentage had declined to 34%. Reductions in incarcerations, psychiatric hospitalizations, and ER utilization have declined from those recorded in September 2017 (see attached).

We should now concern ourselves with the 66% of AOT clients who could benefit from AOT, and have not. This is the population of persons most likely to decompensate to a state of grave disability without treatment, requiring a higher level of care, lengthy IST holds in the jail, referrals to state hospital beds, and LPS conservatorships.

The 2017 AOT report (Dept. of Behavioral Wellness) states:

> "The purpose and intent of Assisted Outpatient Treatment (AOT) is to identify individuals with serious mental illness who are not engaged in treatment, assess if there is a substantial risk for deterioration and/or involuntary detention (under WIC § 5150) which could be mitigated by provision of appropriate services, **and petition the court to order participation in such services if the individual is not able to be successfully engaged by other means."**

We have failed to move beyond the initial stage of AOT outreach or refer even a single case to the civil court. The court component of AOT is essential to its' definition. Without the court component, we do not have an AOT program. Without the court component, our AOT program is hardly more nor less than an Assertive Community Treatment (ACT) program with the addition of referrals by family members.[1] This is a problem. Of what use is our AOT feasibility study if we are not doing AOT?

Clients who could benefit from the court component of AOT (as evidenced by a multitude of studies of AOT programs), arguably those in greatest need of the program, are getting stuck at

the initial outreach stage (27% as of March), and eventually closed to the program (38%) . We are paying a premium in general fund dollars to continue outreach to persons for whom 90-day outreach has not been sufficient to bring them into voluntary treatment.[2] They continue to occupy valuable slots in the pilot program, without moving on to the next step of AOT.

A second highly unusual (unique) aspect of our AOT pilot program is that it is being funded by special allocations from the county general fund. Most other CA counties fund AOT through a combination of MediCal, MHSA, and Realignment (see attached). Only the court component of AOT needs to be funded by general fund, because it is the only component of AOT that cannot by law be funded by other means.

The following recommendations appear to be in order:

1. Adopt the court component of AOT.
2. Identify a different funding stream for AOT. Fund the AOT court component with a more modest allocation of the general fund.
3. Integrate AOT more fully into our existing 300-slot, MHSA-funded ACT program.
4. Appoint an AOT Community Advisory Committee (similar to what exists in some other AOT counties) for the purpose of providing ongoing communication with the Dept. of Behavioral Wellness and Board of Supervisors.

In conclusion, I offer input from an experienced AOT administrator in Nevada County:

"Laura's Law is Medi-Cal and MHSA funded in Nevada County. It is implemented through FSP/AACT (AOT) program services; the individuals who meet criteria for Laura's Law/AOT already qualify for the intensive outpatient services & supports. I'm not aware of any county that uses general funds to provide these services. Whoever is supporting the 300 clients receiving ACT services [in Santa Barbara County], may be able to absorb the (approximately) 5 individuals per 100,000 population, per year. This can be done in various ways, either by implementing smaller ACT/AOT team, or by co-mingling AOT clients within an existing ACT team.. It is the same treatment model. Once, the misinformation is corrected, and there is the collective will to move forward, the county will be able to appreciate the ultimate cost savings associated with AOT."

Respectfully submitted,

Lynne Gibbs (805-708-0856; gibbslyn2@gmail.com)

[1]There is little difference in the outreach and treatment components of AOT and ACT (as as described in the AOT program design of the Board letter, **provided ACT is delivered with fidelity** to the ACT program model:

"The AOT model includes intensive outreach and engagement efforts, as well as wrap-around services, low client-to-staff ratios, provisions for housing, a team-based approach, access to 24/7 team response, and other services or supports provided through flexible funding. AOT services are designed to provide a "whatever it takes" model to keep an individual stable and

functioning in a community setting. The AOT services reduce the need for costly, higher-level services such as involvement with police, probation, or courts, and/or IMD placement for this hard-to-reach and vulnerable population."

This is why the treatment component of AOT is typically delivered within ACT programs, funded as Full Service Partnerships (FSPs) under MHSA. Each of our three regional ACT programs has a capacity of 100 clients. When our AOT program was initiated, no team was serving more than 87 clients.

[2]The AOT stakeholder planning group gave careful consideration in determining an initial outreach period of 90 days, so as to provide enough time to allow for voluntary engagement prior to a court order, but not so long as to prolong unproductive efforts. We are not following this guideline.

# Santa Barbara County Department of Behavioral Wellness

## Assisted Outpatient Treatment Program Report | January - September 2017

The Santa Barbara County Board of Supervisors authorized the court-ordered Assisted Outpatient Treatment (AOT) program for individuals with mental illness who meet the criteria established by Laura's Law. The Department of Behavioral Wellness launched the AOT pilot program in January of 2017, and hired Harder+Company Community Research to conduct an external evaluation of the early implementation and initial outcomes. This report presents findings from the first three quarters of program implementation, January to September 2017.

## Key Findings

**36 people were referred to the AOT program** in the first nine months of 2017. On average, the program received 4 referrals per month. Of those 36 referrals:

Half were from family members, such as parents and children.

67% were under the age of 45.

75% of people had a dual diagnosis.

Half were homeless.

**On average, AOT staff reached out to referred individuals 2 times a week.**

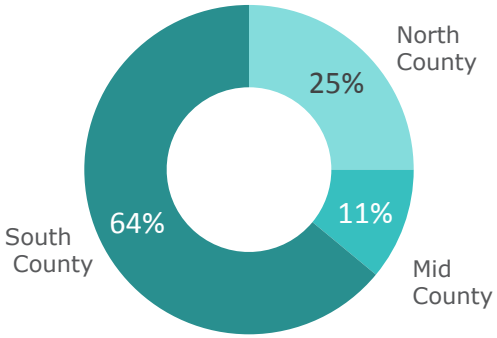
42% of individuals referred to the AOT program voluntarily accepted treatment within the first 6 weeks.

AOT engagement efforts are reducing the number of negative life events for participants.

## Referral Trends

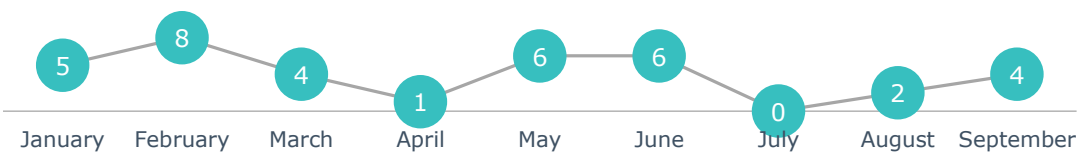
The number of referrals decreased during the third quarter compared to the first and second quarters. Most referrals continued to come from South County communities. Referral rates should be monitored to determine whether the decline in referrals observed this quarter is reflective of needs being met or the need for additional outreach to make potential referrers aware of the AOT program.

### AOT Referrals by Region




### AOT Referrals by Month

Total Referrals: 36
Avg # Referrals/Month: 4




harder+co community research

**Who is participating in the AOT program?** Two-thirds (64%) of the people referred to the AOT program were male. AOT participants ranged in age from 19 to 68 years, and had an average age of 40. At the time of referral, approximately three-fourths (75%) had a dual-diagnosis, half (50%) were homeless, and less than half (44%) were on probation. More than half (56%) identified as Caucasian, and a quarter (25%) identified as Latino or Hispanic.

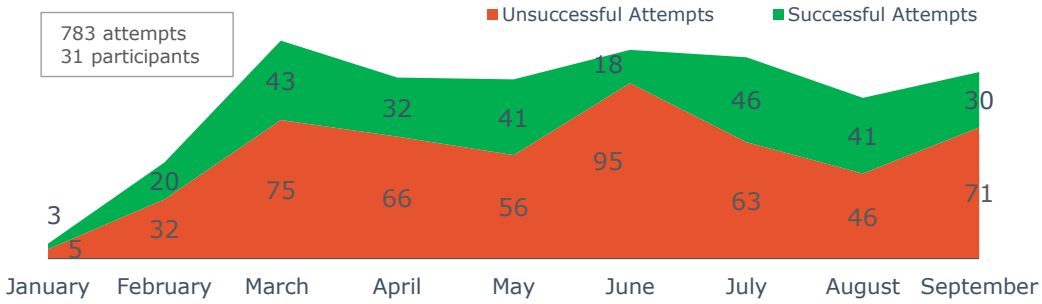
# Engagement Efforts

**How successful is AOT engagement?** The individuals served by AOT are typically hard to reach; they are often homeless, transient, and many experience both substance abuse and mental health concerns.

AOT caseworkers aim to contact all referred clients 3 times a week, with the goal of having individuals accept voluntary treatment. Data show a high level of engagement between caseworkers and referred individuals:

- AOT staff reported **783** engagement attempts (average 2 attempts per week).
- Approximately less than half (45%) of referred individuals have been contacted 3+ times a week (findings include people in the AOT program for over 1 week).
- On average, the AOT team had a 3.5:10 rate of successful contact of referred individuals.

## AOT Engagement Efforts by Month




## Engagement Outcomes

| | |
|---|---|
| **42%** | **Accepted voluntary treatment** |
| 22% | Continue to attempt to engage |
| 0% | Settlement Agreement |
| 0% | Court Petition Filed |
| 0% | Court Ordered to Treatment |
| 36% | Closed* |

**What was the result of AOT engagement efforts?**

Engagement outcomes data show that two-fifths of people referred to AOT (42%) have accepted voluntary treatment and have not needed court intervention thus far.

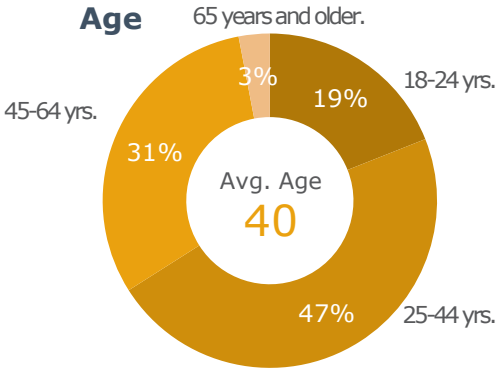
*Unable to locate/Already connected to services/Did not meet AOT criteria

# Characteristics

## Gender

64% Male

## Age




## Race/Ethnicity

| | |
|---|---|
| 56% | Caucasian/White |
| 25% | Latino/Hispanic |
| 8% | Multiracial |
| 6% | Asian |
| 6% | Black/African-American |

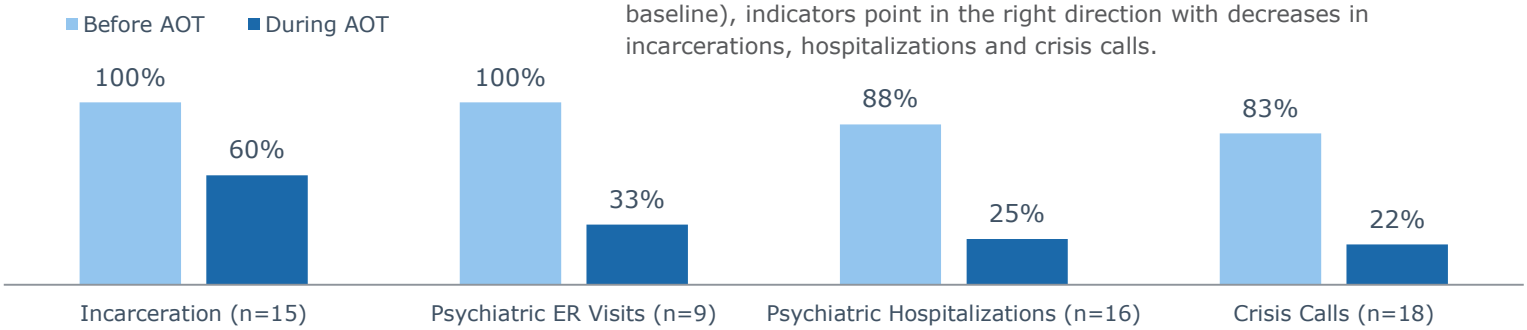
## Other Characteristics

| | |
|---|---|
| 75% | Dual diagnosis |
| 50% | Homeless |
| 39% | Probation |

# AOT Outcomes

**What has changed for AOT participants?** The goal of AOT is to improve access and adherence to intensive behavioral health services in order to avert relapse, repeated hospitalizations, arrest, incarceration, suicide, property destruction, and violent behavior. While early data about the success of AOT in meeting these goals is limited (based on the number of participants who disclosed experiencing each event at baseline), indicators point in the right direction with decreases in incarcerations, hospitalizations and crisis calls.

## Significant Life Events



# Assisted Outpatient Treatment in California

Funding Strategies

7 February 2012

# Assisted Outpatient Treatment (AOT) Components

- Assertive Community Treatment
- Behavioral Health Administration
- County Counsel
- Public Defender
- Judge and court staff
- Law Enforcement
- Psychiatric Hospital

# Assertive Community Treatment

- approximately $20,000/year per individual
- Must meet Welfare and Insitutions Code (WIC) 5348. (a)-(d)
- Mental health treatment costs may be funded by:
  - Realignment
  - Medi-Cal
  - Mental Health Services Act (MHSA)
  - Medicare
  - Private insurance
  - Self pay

# Behavioral Health Administration

- Cost varies and minimal; possibly few new/additional costs, because these same individuals would need administrative time related to, WIC 5350 Lanterman-Petris-Short (LPS) Court, Mental Health Court, public relations, if not being dealt with in AOT Court
- Funded by Medi-Cal, MHSA, realignment

# County Counsel

- Cost varies; but minimal, possibly few new/additional costs, because the Department would need County Counsel involvement and representation related to WIC 5350 LPS Court and Dependency Court, if not being dealt with in AOT Court
- Funded by Behavioral Health Realignment, Medi-Cal, MHSA

# Public Defender

- Cost varies; but, possibly few new/additional costs, because these same individuals would need representation in Criminal Court, WIC 5350 Lanterman-Petris-Short (LPS) Court, Mental Health Court, or Adult Drug Court, if not being dealt with in AOT Court.
- Funded by County General Funds

# Judge and Court Staff

- Cost varies; possibly few new/additional costs, because these same individuals would be in Criminal Court, WIC 5350 LPS Court, Mental Health Court, Dependency Court, or Adult Drug Court, if not being dealt with in AOT Court
- Funded by Superior Court State funds

# Law Enforcement

- Cost varies; but, possibly few new/additional costs, because these same individuals would require law enforcement intervention related to criminal behavior, Mental Health Court, or Adult Drug Court, if not being dealt with in AOT Court
- Funded by County General Funds

# Psychiatric Hospitalization

- ~$800/day, but rarely necessary
- WIC 5346(d) and (f)
- May be funded by Medi-Cal, Medicare, Private Insurance, Behavioral Health Realignment

# Potential Cost Off Sets

- Psychiatric hospitalization; $800/day, potential reduction of 47%
- County Jail; $150/day, potential reduction of 65%
- Emergency Department; $3000/visit, potential reduction of 44%

# What is in the “LPS Act”?

WIC 5000, The Lanterman-Petris-Short Act includes all of the following:

- Detention of Mentally Disordered Persons for Evaluation and Treatment 5150-5157
- Certification for Intensive Treatment 5250-5259.3
- Additional Intensive Treatment 5270.10-5270.65
- The Assisted Outpatient Treatment Demonstration Project Act of 2002, 5345-5349.5
- Conservatorship For Gravely Disabled Persons 5350-5372

# How do counties fund LPS Act services?

- Mostly with Realignment, for example WIC 5150, 5250, 5270, 5350
- But, counties also frequently use Medi-Cal and MHSA funds for mental health treatment associated with these services

# When is Medi-Cal used?

- Medi-Cal is often used for WIC 5150 Assessments and 72 hour hold
- WIC 5250, 14 day additional certification
- WIC 5270, 30 day additional certification
- WIC 5350, *Outpatient treatment* for gravely disabled individuals

# When is MHSA used?

- WIC 5150 Assessment, Evaluation, Mobile Crisis
- WIC 5350 Individuals who are gravely disabled and needing outpatient mental health treatment
- Full Service Partnerships, such as ACT Teams, that target WIC 5350 Individuals who are gravely disabled and needing outpatient mental health treatment

# How to fund AOT?

Why do we think of WIC 5345 so differently from other parts of the LPS Act, even though other parts of the Act contain much more restrictive, disruptive, and costly services?

Why not consider the use of realignment, Medi-Cal, and MHSA where ever possible to pay for AOT?

# Here's the logic…

AOT is a relatively low cost, front end 'prevention' intervention that can greatly reduce the amount of money being directed into high cost, back end services

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