Contra Costa County Assisted Outpatient Treatment (AOT) Evaluation

Evaluation Plan

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Background

In 2004, stakeholders throughout the mental health system in California joined together in support of Proposition 63, the Mental Health Services Act (MHSA). The MHSA was intended to “expand and transform” the public mental health system according to the values of: 1) Recovery, Wellness, and Resiliency; 2) Consumer and Family Driven; 3) Community Collaboration, 4) Cultural Competency; and 5) Integrated Services. MHSA provided an infusion of funds to support Full Service Partnership (FSP) programs, among others, that support the seriously mentally ill and have resulted in positive outcomes. However, the implementation of MHSA did not sufficiently address one of the largest issues facing the mental health community across the nation: the cycle of repetitive psychiatric crises and resulting hospitalizations and incarcerations of the most seriously mentally ill who struggle to engage in services.

California Assembly Bill 1421 (AB 1421), also known as Laura’s Law, was passed in 2002 to address this issue, and authorized the provision of Assisted Outpatient Treatment (AOT) in counties that adopt a resolution to implement AOT. The California Legislature developed AOT to “equitably assign high risk, hard to treat individuals with increased needs in a system with limited resources.”\(^1\) AOT is designed to interrupt the repetitive cycle of hospitalization and incarceration for people with serious mental illness who have been unable and/or unwilling to engage in voluntary services through an expanded referral and outreach process which may include civil court involvement, whereby a judge may order participation in outpatient treatment. AB1421 defines the target population, intended goals, and the specific suite of services required to be available for AOT consumers in California. AOT changes the mental health system in three ways: 1) referral into mental health services; 2) outreach and engagement of individuals into mental health services; and 3) civil court involvement in engaging and supervising individuals with mental health services.

MHSA brought stakeholder communities together, initially in advocacy, and then as required by the MHSA for planning, design, implementation, and evaluation of MHSA-funded services. However, AOT discussions have created fractures within the stakeholder communities, particularly around the tension between family members who perceive AOT as a potential solution to get their loved ones help and consumer groups who perceive AOT as a threat to their civil rights. While these advocacy efforts have occurred at the state level, the discussions have played out at the county level and in front of Boards of Supervisors, who decide whether to adopt a resolution authorizing AOT in their county. While forty-five (45) states have laws authorizing AOT for “qualifying” individuals, New York is the only state with widespread implementation. In California, Nevada and Yolo Counties have achieved full implementation of AOT; Orange, Los Angeles, San Francisco, San Diego, and Contra Costa Counties are in their first year of AOT implementation. Eight additional counties (San Mateo, Placer, Mendocino, El Dorado, Kern, Shasta, Alameda, and Ventura) have adopted, but not yet implemented AOT.\(^2\)

\(^1\) Le Melle, Stephanie. (2013). Assisted Outpatient Treatment, Kendra’s Law, the New York Story. Paper presented at the SAMHSA Seminar on Assisted Outpatient Treatment on December, 12, 2013; Rockville, Maryland.

\(^2\) As of March 14, 2016.
One of the difficulties that has fueled the AB 1421 debate is the lack of conclusive evidence that AOT is more beneficial than the variety of services already provided in California, including voluntary programs and existing legal mechanisms to compel treatment as authorized by the Lanterman-Petris-Short Act (LPS). While the research is clear that people who participate in AOT are likely to experience benefits as a result of participation, there are only two (2) experimental studies that examine the advantages of AOT participation as compared to participation in similar voluntary programs. Both are older studies with methodological challenges and conflicting results. Existing literature does suggest that there are no benefits to consumers of compulsory or mandatory mental health programs when compared to voluntary services. However, there is a substantial gap in the literature about people who are unable and/or unwilling to participate in voluntary services and whether or not AOT is an effective mechanism for engaging and retaining this group in treatment as compared to other engagement mechanisms.

Primary arguments in support of AOT include that:

- In the absence of a way to engage this group of adults with serious mental illness into voluntary treatment, they will not benefit from services nor achieve the outcomes one might expect from engaging with the existing system of care; and
- Outcomes for AOT consumers are better than outcomes for people who do not receive treatment.

Additionally, the body of literature about this target population and AOT has not yet explored what sub-group(s) within populations with serious mental illness may be most likely to benefit from assertive outreach and subsequent service delivery activities that include a court component.

**Program Overviews**

The following section describes the Full Service Partnership program (FSP), Assertive Community Treatment (ACT) service model, and Assisted Outpatient Treatment (AOT). Each section provides an overview of the purpose, specific target population(s), services, and expected outcomes for each. While each program varies in specific eligibility criteria and service delivery model, all three (3) are intended to serve people with serious mental illness who would otherwise be at-risk for being served in institutional settings, such as hospitals and/or jails and prisons, or experience homelessness. The subsequent

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Discussion section describes the differences between the models and how they relate to Contra Costa County’s system of care and respond to the community’s needs.

Full Service Partnership

Within Contra Costa County and across California, Full Service Partnership (FSP) programs are a hallmark of the public mental health system and the MHSA. FSP programs seek to engage people with serious mental illness into intensive, wraparound services with a low staff to consumer ratio (1:10) and that provide a “whatever it takes” approach toward them to:

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

FSP refers to the collaborative relationship between the County and the consumer and when appropriate the consumer’s family. Through this partnership, the County and/or contracted provider plan for and provides a full spectrum of community services so that the consumer can achieve his/her identified goals.7,8

Target Population9

The MHSA details a set of eligibility criteria for FSP programs that vary by age group. For adults, the following criteria must be met for FSP enrollment:

- Their mental disorder results in substantial functional impairments or symptoms, or they have a psychiatric history that shows that, without treatment, there is an imminent risk of decompensation with substantial impairments or symptoms;
- Due to mental functional impairment and circumstances, they are likely to become so disabled as to require public assistance, services, or entitlements; and
- They are in one of the following situations:
  - Homeless or at-risk of becoming homeless;
  - Involved in the criminal justice system; and/or
  - Frequent users of hospital or emergency room services as the primary resource for mental health treatment.
  - They are underserved and at-risk of one of the following:

7 Section 5898, Welfare and Institutions Code
8 Sections 5801, 5802, 5850 and 5866, Welfare and Institutions Code
9 Welfare and Institutions Code section 5600.3, subdivision (b)
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- Homelessness;
- Involvement in the criminal justice system; and/or
- Institutionalization.

Services

The services to be provided for each consumer with whom the County has a FSP agreement may include the Full Spectrum of Community Services, detailed in the MHSA, necessary to attain the goals identified in each person’s Individual Services and Supports Plan (ISSP). The services to be provided may also include services that the County, in collaboration with the consumer and when appropriate the consumer’s family, believe are 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:

- Mental health services and supports including, but not limited to:
  - Mental health treatment, including alternative and culturally specific treatments
  - Peer support
  - Supportive services to assist the consumer, and when appropriate the consumer’s family, in obtaining and maintaining employment, housing, and/or education
  - Wellness centers
  - Alternative treatment and culturally specific treatment approaches.
  - Personal service coordination/case management to assist the consumer, and when appropriate the consumer’s family, to access needed medical, educational, social, vocational rehabilitative and/or other community services
  - Needs assessment
  - ISSP development
  - Crisis intervention/stabilization services
  - Family education services
- Non-mental 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

10 9 CA ADC §3620
Expected Outcomes

FSPs are intended to positively affect a variety of outcomes for its consumers. In particular, as noted above, FSPs are designed to:

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

Timothy Brown’s (2010) UCLA study of FSP programs across California found that FSP programs improve outcomes for program participants across a range of categories (e.g., housing, education, and employment) as well as reduce hospital visits and arrests. Moreover, as compared to usual care across California counties (approximately 85% of counties in California were included in the analyses), Brown found that FSPs effectively decrease mental health related hospitalizations and arrests and cause large improvements in consumers’ functioning, outcomes of services, and satisfaction.11

Assertive Community Treatment

Assertive Community Treatment (ACT) is an evidence-based behavioral health program for people with serious mental illness who are at-risk of or would otherwise be served in institutional settings (e.g. hospitals, jails/prisons) or experience homelessness. ACT has the strongest evidence base of any mental health practice for people with serious mental illness, which dates back to the 1970s. When done to fidelity, ACT produces reliable results that decrease consumers’ negative outcomes such as hospitalization, incarceration, and homelessness and improve psychosocial outcomes, described above.

Target Population

While FSP and AOT program models have clearly stated eligibility criteria, each ACT service delivery team must develop administrative rules for admission into ACT services. Typically, in order to be eligible for ACT, consumers must meet the locally-defined eligibility criteria; in California, ACT eligibility criteria are primarily defined by the funding source. Generally speaking, ACT is a model that is implemented for people with serious mental illness who are experiencing frequent and repetitive hospitalizations and/or incarcerations, are likely to be homeless, and may suffer from a co-occurring disorder.

Services

The ACT model is a comprehensive community-based model of treatment, support, and rehabilitation for individuals who have serious and persistent mental illness, and who do not seek-out support and/or have trouble engaging in traditional office-based programming. Often referred to as a “hospital without walls” in which the ACT team itself provides the community support, ACT teams are characterized by:

- An interdisciplinary team with a low staff to consumer ratio that includes specific positions, including team leader, psychiatrist (1:100) ratio, nurse (1:50), vocational and substance abuse specialists (1:50), and peer counselor.

- A team approach to care in which: 1) all ACT team members know and work with all ACT consumers, and 2) a practicing ACT team leader spends more than 50% of his/her time providing direct services to ACT consumers.

- A high frequency and intensity of community-based services with at least four (4) face-to-face contacts per week for a minimum of two (2) hours total per week, and where at least 80% of services are provided in the community, not in the office.

- Assertive engagement mechanisms that allow for longer periods of outreach prior to treatment admission, including street outreach, working with informal support networks (e.g., family, landlord, employer) and coordination of legal mechanisms such as outpatient commitment and court orders.

- ACT teams assuming total responsibility for treatment services, including crisis response, so that all service needs can be met by ACT staff members who are available 24 hours per day, 7 days per week, 365 days per year.

- Time-unlimited services, so that ACT consumers can receive ACT services for as long as they are a part of their county’s ACT program.

When the ACT model is modified, the reliability of expected outcomes is lessened. In other words, modified ACT programs are still likely to produce similar results, but to a lesser degree and with less consistency.

Expected Outcomes

According to findings from 25 randomized controlled trials, compared to usual community care, ACT services more successfully engage consumers into treatment, substantially reduce psychiatric hospital use, increase housing stability, and moderately improve symptoms and subjective quality of life.12

Moreover, ACT programs are no more expensive than other types of community care service models and produce greater consumer and family satisfaction.\textsuperscript{13} Perhaps more importantly, research also suggests there are no negative outcomes associated with the ACT service delivery model.\textsuperscript{14} Recent research seeking to identify which consumer populations for whom ACT is most effective for suggests that ACT is strongly effective and cost-effective for consumers with high frequencies of psychiatric hospitalizations, and less effective and not as cost-effective for consumers with low frequencies of psychiatric hospitalizations.\textsuperscript{15} Moreover, studies also find significant and positive associations between ACT participation and lower levels of substance use among program participants with dual diagnoses.

While vast research has demonstrated positive outcomes associated with ACT services, research based in the United Kingdom and United States has not found consistently better outcomes for ACT services compared to usual community care service models in areas with established and robust mental health service infrastructures in place. In these areas, established quality mental health care services absorb the positive outcomes of ACT.\textsuperscript{16} Moreover, ACT services may also not be well-suited in rural settings because sparsely populated communities often lack a critical mass of service users that require intensive mental health services.

While maintaining fidelity to the ACT model is important for programs seeking to achieve the expected outcomes noted above, some of the core original ACT components have not endured. In particular, a time-unlimited approach to ACT does not appear to be evidence-based, recovery-oriented, practical, or cost-effective; therefore, this approach has been replaced with one encouraging graduation.\textsuperscript{17}

**Assisted Outpatient Treatment**

Assisted Outpatient Treatment (AOT) is an umbrella term that describes a legal process whereby a judge may mandate or compel a person with serious mental illness to comply with a treatment plan on an outpatient basis. The specific target population, suite of services, legal processes, and enforcement mechanisms varies by state. In California, AB 1421 legislation authorizes and outlines AOT criteria for California counties that opt-in to implementing AOT.

**Target Population\textsuperscript{18}**

AB 1421 sets forth the following eligibility criteria for AOT. In order to be eligible, the person must be referred by a “qualified requestor”\textsuperscript{19} and meet all of the defined criteria.

\begin{itemize}
  \item \textsuperscript{14}Bond, G.R. (2002). Assertive Community Treatment for People with Severe Mental Illness. *Behavioral Health Recovery Management Project*.
  \item \textsuperscript{16}ibid
  \item \textsuperscript{17}ibid
  \item \textsuperscript{18}Welfare and Institutions Code Section 5346
\end{itemize}
The person is 18 years of age or older.
- The person is suffering from a mental illness
- There has been a clinical determination that the person is unlikely to survive safely in the community without supervision.
- The person has a history of lack of compliance with treatment for his or her mental illness, in that at least one of the following is true:
  - a. At least 2 hospitalizations within the last 36 months, including mental health services in a forensic environment.
  - b. One or more acts of serious and violent behavior toward himself or herself or another, or threats, or attempts to cause serious physical harm to himself or herself or another within the last 48 months.
- The person has been offered an opportunity to participate in a treatment plan by the director of the local mental health department, or his or her designee, provided the treatment plan includes all of the services described in Section 5348, and the person continues to fail to engage in treatment.
- The person's condition is substantially deteriorating.
- Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure the person's recovery and stability.
- In view of the person's treatment history and current behavior, the person is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to himself or herself, or to others, as defined in Section 5150.
- It is likely that the person will benefit from assisted outpatient treatment.

**Services**

AOT implementation includes the provision of mental health and legal services for its consumers. The particular suite of mental health services that each county chooses to provide to its AOT consumers varies by county. Although the legislation sets forth certain requirements for service availability, civil court involvement is the process in which counties engage potential AOT consumers into mental health services and is the mechanism by which AB 1421 legislation authorizes and promotes acceptance of and continued participation in mental health services.

**Mental Health Services**

The mental health services described in AB 1421 legislation include a community-based, mobile, multidisciplinary, highly trained mental health team that uses low staff-to-consumer ratios of no more than 10 consumers per team member and includes a personal service coordinator. Services that must be available as a part of an AOT program includes:
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- Outreach and engagement services, including outreach and engagement for people who are likely to encounter potential AOT participants (i.e. family, physicians, law enforcement, other treatment providers)
- Coordination and access to medications, psychiatric and psychological services, and substance abuse services
- Supportive housing or other housing assistance
- Vocational rehabilitation
- Veterans’ services
- Family support and consultation services
- Parenting support and consultation services
- Peer support or self-help group support, where appropriate
- Age, gender, and culturally appropriate services

Legal Services

AOT also includes a civil court procedure that must be initiated by the County Mental Health Director, or designee, if a person:

- Has been referred to the AOT program by a qualified requestor (i.e. law enforcement officer, member of persons household, mental health clinician serving person, and the director of the facility the individual is hospitalized in);
- Has not agreed to accept services on a voluntary basis during an outreach and engagement period; and
- Meets all eligibility criteria.

In an AOT program, the Mental Health Director, or designee, may file a petition with the Court to initiate an AOT hearing if the mental health department is unable to engage the person in services on a voluntary basis. If the person agrees to participate in AOT at the first hearing, they enter into a voluntary settlement agreement with the Court that specifies the particular treatment services that the person has agreed to accept. If the person does not agree at the first hearing, a second hearing is scheduled. If the person agrees to participate in AOT at the second hearing, the judge may issue an AOT Court Order that specifies the specific treatment services that the person has agreed to accept.

Contra Costa’s AOT Program Design

Contra Costa County has designed an AOT program that exceeds AB 1421 requirements and responds to the needs of its communities. The Contra Costa County AOT program includes a Care Team staffed by a County clinician, family advocate, and peer counselor as well as an ACT team operated by Mental Health Systems (MHS), a contracted provider organization.

The first stage of engagement with Contra Costa County’s AOT program is through a telephone referral where any qualified requestor can make an AOT referral. Within five business days, a mental health
A clinician will reach out to the requester to gather additional information. If the person appears to initially meet eligibility criteria, the Care Team will facilitate a face-to-face meeting with the family and/or consumer to gather information, attempt to engage the consumer, and develop an initial care plan. If the consumer continues to appear to meet eligibility criteria, the Care Team will provide a period of outreach and engagement while furthering the investigation to determine eligibility. If at any time the consumer accepts voluntary services and continues to meet eligibility criteria, he/she will be immediately connected to and enrolled in ACT services.

However, if after a period of outreach and engagement, the consumer does not accept voluntary services and continues to meet criteria, the County mental health director or designee may choose to file a petition with the court. Contra Costa County will then hold 1-2 court hearings to determine if criteria for AOT are met. At this time, the individual may enter into a voluntary settlement agreement to receive ACT services, or be ordered to AOT for a period of no longer than six months. After six months, if the judge deems that the person continues to meet AOT criteria, they may authorize an additional six-month period. At every stage of the process, CCBHS will continually offer the individual opportunities to voluntarily engage in services and may recommend a 72-hour hold, at any stage of the process, if they meet existing involuntary criteria. The following flow chart depicts this process.
Figure 1. Contra Costa County AOT Client Engagement Process Flowchart
Expected Outcomes

Most research assessing the effectiveness of AOT uses a pre-/post-test or quasi-experimental design and suggests that AOT consumers do experience benefits from participation. However, the benefits are generally similar to the benefits one would expect from participating in ACT services or a similarly intensive case management program, including outcomes such as decreased hospitalization and increased psychosocial functioning. Therefore, while research evaluating the efficacy of AOT generally reinforces that the mental health services provided to AOT consumers are effective, it does not help us understand if the particular mental health services, which have an evidence base, are responsible for the benefits or if the AOT-specific intervention (both mental health services and court involvement) is responsible for the benefits experienced beyond those of solely receiving the mental health services.

Two randomized control trials sought to determine whether an AOT court order is responsible for the benefits experienced by consumers beyond the provision of just mental health services, the "Duke Study" from North Carolina and a study from New York state. Both are older studies with some methodological challenges, such as issues related to consistency of the intervention, and they have conflicting results. The Duke Study found resoundingly positive outcomes for AOT consumers when compared to those receiving mental health services only. Moreover, the Duke Study results, demonstrated that AOT consumers who underwent sustained and relatively intensive treatment had fewer hospital admissions and spent fewer days in the hospital, and were also less likely to be violent or victimized. In addition, AOT consumers were more likely to adhere to community-based treatment than individuals who had not received a court order. These findings suggest that AOT participation resulted in positive outcomes for consumers and served as a mechanism to increase engagement in AOT services.20

While these findings lend support for utilizing AOT in North Carolina, findings from the New York Study show no significant differences between individuals who received services and a court order versus those who only received mental health services.21

Discussion

The AOT program in Contra Costa County presents four issues of interest to both the program’s implementation as well as its evaluation. These areas of interest will be focal points for exploration throughout the Contra Costa County AOT program implementation period. First, there is little evidence that explores who may be best served in a voluntary program and who may be most likely to require and subsequently benefit from AOT services. Second, understanding how people with serious mental illness who are not yet receiving ongoing mental health services become engaged in non-crisis mental health services, and particularly the AOT program, is important for determining how to best target outreach efforts. Next, as consumers are receiving Contra Costa County’s FSP or AOT services,

understanding the factors that affect their service participation and retention, specifically as it pertains to the AOT intervention, will allow Contra Costa County to best identify individuals with serious mental illness who are most likely to benefit from AOT. Lastly, given the current literature gaps in the expected outcomes for AOT programs and consumers, this AOT program and evaluation in Contra Costa County will produce meaningful information to contribute to the growing evidence base for AOT about for whom AOT is most likely to benefit.

Consumer Profile

Contra Costa County’s AOT consumers will consist of a diverse population with a wide variety of distinguishing characteristics. In order to understand the underlying dynamics of AOT and FSP treatment engagement, retention, and outcomes, it is important to establish a comprehensive understanding of who is served within each program. In particular, the evaluation is interested in specific variables that comprise the consumer profiles, including their demographics, service histories, and clinical profile. Particular variables of interest include AOT consumers’ race/ethnicity, gender, housing status, education level, income level; diagnoses, substance use patterns, and co-morbid medical conditions; and service history including PES and hospitalization visits, incarceration, and participation in other mental health services. By understanding these variations, CCBHS may be able to best target AOT outreach and engagement strategies as well as AOT services provision.

Engagement

FSP, ACT, and AOT are all intended to interrupt the cycle of hospitalization, incarceration, and homelessness for people with serious mental illness who are unable and/or unwilling to participate in and/or benefit from services. However, the last ten (10) years of FSP implementation across the state suggest that:

- People who are engaged in FSP services, whether they seek services independently or with support, generally experience reduced hospitalization, incarceration, and homelessness.
- There are people who are not engaging in FSP programs and who are continuing to experience a repetitive cycle of hospitalization, incarceration, and homelessness.

There are four potential reasons why someone with a high degree of acuity and need may be unwilling and/or unable to engage in FSP services:

- A percentage of people with serious mental illness do not have an awareness that they are ill and do not recognize their need for mental health treatment.\(^{22}\) This is more common in those with schizophrenia, bipolar, and other psychotic disorders.\(^ {23}\)


Some adults with mental illness, specifically those with repeated crisis and hospital events, may have experienced trauma and/or stigma related to seeking or receiving mental health services and, therefore, may avoid engaging in mental health treatment and may have co-occurring substance use disorders.24, 25

Some adults may experience difficulty accessing or navigating the mental health system as a result of barriers to access, limited resources or capacity issues, or “falling through the cracks” when moving between levels of care.26

The California public mental health system is at capacity and may not have the resources to engage in non-billable, assertive outreach efforts for those who don’t seek services or readily accept them when offered.

These reasons for non-engagement suggest the need to consider alternate methods for engaging people in treatment, such as AOT. AOT provides a significant change in the way in which people may be identified and engaged in treatment. Without an AOT program, individuals receive treatment when they are:

- Assessed to meet criteria for involuntary care such as authorized by W&I 5150, W&I 5250, or LPS conservatorship(s); and
- Seek or accept help to seek voluntary services.

AOT expands this by providing a mechanism for other individuals in a person’s life to help the mental health department become aware of someone who may have a high degree of need for mental health services and be otherwise unable to engage in those services. With AOT, the mental health department is authorized and required to provide a mental health assessment and subsequent outreach to people, each referred by a qualified requestor, who appear to meet AOT criteria.

Service Participation and Retention

Contra Costa County has a comprehensive system of care in place for adults who suffer from serious mental illness that includes psychiatric crisis and emergency services, inpatient, crisis residential treatment as an alternative to inpatient hospitalization, residential, full service partnerships, and outpatient programs that include day treatment, vocational, and peer support. Programs are located throughout the County through a network of County-operated behavioral health clinics and community-based providers with the majority of crisis services located in the central region. Contra Costa County

25 News and Notes, “MHA Survey Shows Progress in Public Knowledge About Mental Disorders, but Stigma Remains a Problem,” *Psychiatric Services*, vol. 58 (July 2007)
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has operated FSP programs since 2006, which are administered by contracted community based organizations.

Despite having a vast service infrastructure and an array of services available, there are individuals in Contra Costa County who cycle in and out of the highest levels of care and are unwilling and/or unable to engage in regular, ongoing mental health care services. For this population who experiences repetitive crisis events and hospitalizations, AOT provides not only an additional mechanism to engage these individuals in ACT services that are likely to be beneficial but also a mechanism to monitor and retain these individuals in care.

While ACT is not a required element of an AOT program in California, Contra Costa County has committed to provide high fidelity ACT services for any person who is:

1. Referred to AOT by a qualified requestor; and
2. Meets AOT eligibility criteria, as set forth in the AB 1421 legislation.

Given the “no-fail” element of ACT programs and ACT’s demonstrated efficacy in serving this population, combined with the possibility for court participation to compel treatment at six (6) month intervals, Contra Costa County’s ACT/AOT program is designed to not only engage but retain the target population in services.

Expected Outcomes

As discussed above, there are gaps in the literature about AOT and challenges in applying the existing body of literature to California and specifically in Contra Costa County. While the literature is inconclusive for whether or not AOT offers benefits beyond what one would expect from engaging in the same or similar voluntary services,\(^27\), \(^28\) and consistently suggests that voluntary services are preferable,\(^29\) the literature does not address the issues of engagement and retention. If one assumes that, for the target population, participation in services produces better results than participation in no services and that the target population is, by definition, one who cannot or does not engage in voluntary services, the question of whether or not voluntary services produce more positive results may be flawed. The more applicable questions are:

- For whom is AOT most beneficial? Do the characteristics and outcomes of consumers who voluntarily engage differ in a systematic way from those who participate in services with court involvement?


How effective is AOT in engaging and retaining individuals in treatment? How, if at all, does court involvement impact engagement and retention in services?

Moreover, in Contra Costa County, FSP and AOT services are intended to reduce the County’s overall costs of care for persons with serious mental illness. In particular, an overarching goal of these services is to shift these persons’ involvement from high-cost services, such as hospitalization and incarceration, to ongoing engagement in mental health services, which are significantly less costly to the County. Therefore, a major expected outcome of Contra Costa County’s AOT program is the overall reduction in costs for AOT consumers.

Evaluation

Resource Development Associates, in partnership with Drs. Jeffrey Swanson and Marvin Swartz from Duke University, will provide external evaluation services to this project to best understand the role of ACT and AOT in Contra Costa County’s system of care. It is expected that this evaluation will: 1) meet annual DHCS reporting requirements; and 2) provide information to the Board of Supervisors, Contra Costa Behavioral Health Services, stakeholders, and the public about the programmatic and cost effectiveness of CCBHS’ 36-month AOT pilot project.

Evaluation Plan

Purpose of Evaluation

This is a four-year evaluation that will measure the implementation and outcomes of Contra Costa County’s AOT program. The evaluation aims to:

1. Meet Department of Health Care Services (DHCS) reporting requirements for AOT programs;
2. Provide information regarding CCBHS’ AOT pilot program, including contributing to the understanding of AOT, its role, and benefits within CCBHS’ adult system of care; and
3. Explore how CCBHS’ AOT program engages and retains consumers in treatment and determine outcomes achieved.

Research/Evaluation Questions

Research and evaluation questions reflect the purpose of the evaluation and help to guide evaluation activities, ensure that appropriate data are collected, and address local priorities. RDA will provide CCBHS with a rigorous evaluation that complies with DHCS reporting requirements and provides information that informs the County regarding AOT implementation, including individual-, systems-level, and cost outcomes of AOT implementation. This evaluation has set forth the following four evaluation questions:

1. How faithful are ACT services to the ACT model?
Contra Costa has designed an AOT program that provides high fidelity ACT services to people who are: 1) referred to AOT; and 2) meet AOT eligibility criteria, regardless of whether or not they require court involvement to participate. Given that ACT, when done to fidelity, produces reliable outcomes, this evaluation includes an ACT fidelity assessment that will provide a numerical rating of the extent to which ACT services are in alignment with the ACT model.

The ACT Fidelity Assessment is a standardized assessment developed by Dartmouth University and codified by SAMHSA in an ACT evaluation toolkit. This standardized assessment provides individual, numerical ratings for 28 criteria across three domains (e.g., Human Resources, Organizational Boundaries, and Nature of Services) and also results in a composite score. The ACT Fidelity Assessment has a clearly defined approach that includes two (2) qualified assessors engaging in a series of activities that include chart reviews, observations, interviews, and focus groups to assess fidelity as well as individual scoring of each criteria and a meeting to develop consensus for the final ratings.

Given the strength of the research supporting the ACT model, it is reasonable to assume that ACT will produce reliable results when implemented to fidelity. In support of this, the ACT Fidelity Assessment will also contribute toward clear and targeted recommendations to increase implementation fidelity, thereby improving the likelihood that the program will achieve expected outcomes. RDA plans to conduct a fidelity assessment of Contra Costa’s ACT team on an annual basis in the 2nd and 3rd years of AOT implementation, timed to coincide with annual DHCS reporting requirements.

2. What are the outcomes for people who participate in AOT, including the DHCS-required outcomes?

This evaluation will investigate the outcomes for people who participate in AOT, regardless of court involvement. The literature suggests that people who participate in AOT experience decreases in negative outcomes and increases in positive outcomes, described in the preceding section. Contra Costa County seeks to determine what specific outcomes are achieved by its AOT participants. Additionally, DHCS requires that each County who adopts and implements AOT report on specific outcomes. This research questions will meet local and state objectives to better understand the outcomes of AOT participants.

To answer this evaluation question, a pre-/post-test research design will be used. Baseline data will first be collected about identified outcomes when someone enters the program. The same data will then be collected at subsequent regular intervals and analyzed to document change over time. These analyses will be repeated semi-annually in order to provide interim reports to the County, stakeholders, and Board of Supervisors as well as meet annual reporting requirements for DHCS.

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30 [http://www.dartmouth.edu/~implementation/page15/page4/files/dacts_protocol_1-16-03.pdf](http://www.dartmouth.edu/~implementation/page15/page4/files/dacts_protocol_1-16-03.pdf)
3. **What are the differences in demographics, service patterns, psychosocial outcomes, and cost between those who participate in AOT without court involvement and those who participate with a court order or voluntary settlement agreement?**

This evaluation question is designed to compare those who are referred to AOT and choose to participate without court involvement and those who are referred to AOT and require court involvement to participate. This evaluation question explores:

- **What, if any differences, exist between AOT participants who participate prior to court involvement and those who participate with court involvement?** In other words, are there characteristics that can be identified which explain who may be able more likely to engage prior to court involvement through the outreach and engagement process versus those who are unlikely to engage without court involvement? These characteristics may include demographic characteristics, clinical profile, and service histories. Increasing this understanding may inform how to best target outreach and engagement efforts.

- **What are the differences in outcomes, including cost, for those who participate prior to court involvement and those who participate with court involvement?** While the previous question is one regarding engagement, this question seeks to understand if there are differences in outcomes, including treatment adherence and retention, in the AOT program, based on the presence of court involvement. In other words, are there differences in outcomes that help explain who is most likely to benefit from AOT, specifically court involvement?

Participant, service, and outcome data will be collected throughout the AOT program and will be analyzed at the end of the study period.

4. **What are the differences in demographics, service utilization, psychosocial outcomes, and cost between those who engage in existing FSP services and those who participate in AOT with no court involvement?**

This research question compares the group of people participating in AOT, regardless of court involvement, with people participating in FSP services. This question is intended to examine the addition of AOT and ACT to the existing system and similar programming. The purpose of this evaluation question is to understand the differences between individuals participating in AOT with those participating FSP services, thus allowing CCBHS to most effectively identify, engage, and retain participation in AOT as well as understand the role of the court. Specifically, this fourth research question considers:

- **What, if any differences exist between those who are able to participate in FSP services versus those who are unable to participate without the additional supports and provisions included within AOT?** In other words, are there characteristics that can be identified which explain who may be able more likely to engage in FSP services versus those who are unlikely to engage without AOT? These characteristics may include demographic characteristics, clinical profile, and service histories. Increasing this understanding may inform how to best target outreach and engagement efforts.
What are the differences in services provided by FSP versus AOT? Given that both models are intended to serve similar populations with a flexible, interdisciplinary team, this question will explore the differences in service frequency and intensity of FSP services as compared to ACT.

What are the differences in outcomes, including cost, for those who are able to participate in FSP services versus those who are unable to participate without the additional supports and provisions included within AOT? Given the potential differences in persons served and actual services provided, there may also be differences in outcomes between the two groups that may inform future service designs and/or modifications as well as treatment assignments.

Participant, service, and outcome data will be collected throughout the AOT program and will be analyzed at the end of the study period.

Target Population and Sampling

The target population for this study is adults ages 18 or older with serious mental illness who are enrolled in AOT or FSP services and are residents of Contra Costa County. The specific sample populations vary by research question.

Evaluation Question #1 Sample: All consumers receiving AOT services who will be included in the ACT Fidelity Assessment sample.

Evaluation Question #2 Sample: All consumers receiving AOT services who will be included in the pre-/post-test outcome evaluation.

Evaluation Question #3 Sample: Consumers who are receiving AOT services and have Medi-Cal coverage will be included in these analyses. Consumers with private insurance will be excluded from this study because of issues related to obtaining private insurance data.

Evaluation Question #4 Sample: Consumers who are receiving FSP or AOT services and have Medi-Cal will be included in these analyses. Consumers with private insurance will be excluded from this study because of issues related to obtaining private insurance data.

Sample Size Limitations

In addition to the abovementioned inclusion and exclusion criteria, RDA will also take into account sample sizes (i.e., the number of consumers participating voluntarily versus with court involvement). Although Contra Costa County’s AOT program may serve 75 persons, the distribution of consumers receiving services with or without court involvement is not yet known. The distribution across this variable may limit the types and strength of analyses performed, specifically for evaluation question #3.

Evaluation Methods

In this portion of the evaluation plan, RDA discusses the evaluation methods that will be employed. This includes a discussion of the overall mixed methods approach, data sources and collection methods.
section also includes additional information explaining the purpose of the proposed data analyses and the analytic methods that the evaluation team will utilize.

**Mixed Methods Approach**

For the purposes of this evaluation, RDA will utilize a mixed methods approach that includes both quantitative and qualitative data collection and analyses. There are varieties of mixed methods approaches, all of which combine or integrate qualitative and quantitative data to maximize the strengths of the data while minimizing the weaknesses. Mixed methods research designs generally fall into two categories: 1) collecting qualitative and quantitative data concurrently and integrating data during the analysis; or 2) collecting and analyzing one type of data first (qualitative or quantitative) and then using the results to inform the next phase of the project where the other type of data will be collected. RDA plans to use both approaches in this evaluation. The evaluation team may integrate qualitative and quantitative data analyses in various ways, including:

**Consecutive Approaches**

- Quantitative results may direct qualitative inquiry. For example, findings from the semi-annual quantitative analyses may suggest questions for a future focus group or interview.

- Qualitative results may direct quantitative inquiry. For example, an emerging theme from the qualitative data may suggest a phenomenon or additional quantitative analyses not yet considered.

**Concurrent Approaches**

- Use of qualitative data to contextualize the results of the quantitative analysis.

- Use of qualitative data to support or refute quantitative results.

- Quantifying qualitative data (e.g., number of occurrences of a theme) to compare to quantitative results.

RDA’s evaluation team will be flexible in adapting its analytic procedures in order to accommodate the quantity and quality of data obtained over the course of the evaluation.

**Data Sources and Collection**

RDA will rely on numerous data sources in order to answer the evaluation questions and complete the fidelity assessment and outcome evaluation of CCBHS’ AOT program. The AOT program intends to implement validated psychosocial assessments, scales, and questionnaires in the provision of care to

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AOT consumers. Mental Health Systems (MHS), the contracted provider for Contra Costa County, will be the primary point of contact for data related to AOT program consumers and will store their data electronically in their EHR. For AOT consumers, MHS will follow each assessment’s schedule of implementation for the purposes of service provision (refer to Appendix II. Contra Costa County ACT/AOT Assessment Schedule). In addition, CCBHS will be the primary source of data for service history of AOT and FSP consumers. For the evaluation, RDA will utilize the historical data already collected by CCBHS in their EHR. Additionally, RDA will rely on data from other Contra Costa County data systems for non-mental health related data. Below is an outline of the type and sources of data that RDA will use to answer each research/evaluation question as part of the evaluation of AOT program in Contra Costa County.

Fidelity Assessment Data Sources and Collection

In order to examine how faithful CCBHS’ ACT services (provided to all AOT consumers) are to the ACT model, RDA will utilize the ACT Fidelity Assessment Tool and qualitative data collected during the annual assessment. RDA plans to utilize the ACT Fidelity Scale, developed at Dartmouth University, as codified in a toolkit for ease of administration. The ACT Fidelity Scale is a 28 program-specific scale where researchers rate items on a 5-point scale ranging from one (not implemented) to five (fully implemented). The scale items fall into three categories: human resources (structure and composition); organization boundaries; and nature of services.

As ACT is an evidence-based practice, there are specific aspects of program delivery that must be included to ensure that the program meets the standards set forth in the program model. By measuring fidelity, the evaluation will help to ensure that AOT consumers are receiving an equitable level of ACT services while also providing a benchmark from the literature about expected outcomes. By assessing program fidelity on a yearly basis, RDA and CCBHS can also examine the quality of service provision and track improvements in administering ACT services to fidelity.

For the fidelity assessment, RDA will utilize qualitative data sources by conducting site visits/observations at the program site, as well as conducting discussions and interviews with consumers, families/caregivers, and ACT team members during the fidelity assessment. While facilitating interviews and focus groups, the evaluation team will use protocols with specific questions in order to collect consistent and relevant data during these activities. Lastly, RDA will request data from Mental Health Systems regarding staffing, service related policies, as well as examine treatment models and the number of consumers served. For the complete Fidelity Assessment Packet please refer to Appendix IV. ACT Fidelity Assessment Packet.

The ACT fidelity assessment tool has predetermined documentation that RDA must receive, as well as discussions with certain stakeholder groups, in order to successfully complete the fidelity assessment.

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33 http://www.dartmouth.edu/~implementation/page15/page4/files/dacts_protocol_1-16-03.pdf
Table 1 describes the ACT fidelity assessment activities that RDA shall perform during the fidelity assessment and outlines the purpose of each activity and the types of information RDA will collect.

<table>
<thead>
<tr>
<th>Fidelity Assessment Activity</th>
<th>Purpose of Activity</th>
<th>Number of Participants</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staffing Documentation</strong></td>
<td>❖ To identify ACT team staff capacity, position, duration of employment (over 2 years), and vacancies (over 1 year)</td>
<td>Not applicable</td>
<td>2 years</td>
</tr>
<tr>
<td><strong>Program Documentation</strong></td>
<td>❖ To identify admission criteria, ACT program design, and information sharing strategies</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
| **Consumer Information** | ❖ To identify hospital admission information for ACT consumers (last 10 admissions)  
❖ To explore descriptive information such as co-occurring disorders, living situation, employment, and demographics  
❖ To examine ACT and non-ACT service provision information including types of services and admission and discharge dates  
❖ To identify type of service provider type | Not applicable | Not applicable |
| **Team Meeting Observation** | ❖ To observe the team approach to care | Not applicable | Day of Site Visit |
| **Team Leader/Clinical Director Interview** | ❖ To discuss ACT team staffing, meetings, consumer ratios, admission criteria and intake  
❖ To explore service provision, substance abuse treatment, engagement and discharge policies and procedures | 2 participants | 60 minutes |
| **Team Member Interviews** | ❖ To explore service provision, approach to care, and treatment philosophy  
❖ Interviews will take place with the following staff:  
 o Clinicians;  
 o Nurses;  
 o Peer Counselors; and  
 o Substance Abuse Specialists | 4 participants | 45-60 minutes |
| **Consumer Discussion** | ❖ To discuss consumer experiences with the ACT service provision model, interactions, and the services received | 1 group  
❖ ~10 persons per group | 90 minutes |
| **Family Member Discussion** | ❖ To explore family member’s involvement with ACT team and provision of care to their family member | 1 group  
❖ ~10 persons per group | 90 minutes |
RDA staff who are qualified to conduct the fidelity assessment will moderate and coordinate all logistics for the ACT fidelity assessment activities at the program site. RDA will use the discussion and interview components of the fidelity assessment to assess implementation of ACT services in the County from various perspectives:

- **Consumer and family member discussions** will used to obtain information from the consumer and their family members/caregivers on their perception of the Contra Costa AOT model, service provision, team approach to care, treatment philosophy, what has worked well for them, and recommendations for service provision improvements. Approximately 10 persons will be included in two to three groups and each discussion will last approximately 90 minutes.

- **Team leader and team member interviews** will help RDA understand service provision, treatment philosophy, and team approach. Questions for these activities include items such as examining the outreach/engagement process, exploring roles and responsibilities, examination of treatment models, techniques in engaging hard to engage consumers, etc. These interviews will take place with four (4) of the ACT Team members and will take between 45-60 minutes.

- **Documentation and Service Provision Reviews** will be used to examine information on staffing, staffing vacancies, program admission criteria, and the treatment models, as well as other consumer and service information.

**Outcome Evaluation Data Sources and Collection**

In order to answer the outcome research/evaluation questions above (questions 2-4), RDA will rely on the quantitative data sources collected by CCBHS, Mental Health Systems, and other County agencies, such as the Superior Court and Sheriff’s Office. As stated above, the three outcome evaluation questions of interest are:

1. What are the outcomes for people who participate in AOT, including the DHCS-required outcomes?
2. What are the differences in demographics, service patterns, psychosocial outcomes, and cost between those who participate in AOT without court involvement and those who participate with an AOT court order or voluntary settlement agreement?
3. What are the differences in demographics, service utilization, psychosocial outcomes, and cost between those who engage in existing FSP services and those who participate in AOT without court involvement?

In exploring the DHCS requirements and the questions of interest to Contra Costa, RDA identified four areas of inquiry for the purposes of this evaluation: 1) consumer profile; 2) outreach and engagement; 3) level of service, participation, & retention; and 4) outcomes, including costs. These four areas of inquiry will help to guide the evaluation and ensure that data is collected in similar and consistent manners so that the evaluation team is able to accurately report on information for both AOT and FSP consumers.
In this section of the evaluation plan, RDA outlines the areas of inquiry, the DHCS reporting requirements, data elements, data sources, and the responsible agency that shall supply the data to RDA. Table 2 below identifies the DHCS reporting requirements, as mapped to the areas of inquiry, their data elements, sources, and agency from which RDA will request the data from. As described in the statute, the DHCS reporting requirements are for AOT individuals, and thus RDA will report on these requirements solely for AOT consumers.

Table 2. Areas of Inquiry Mapped to Department of Health Care Services Reporting Requirements Related to Evaluation Question Two

<table>
<thead>
<tr>
<th>Area of Inquiry</th>
<th>DHCS Reporting Requirement</th>
<th>Data Element</th>
<th>Data Source</th>
<th>Responsible Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer Profile</td>
<td>The number of persons served by the program and, of those, the number who are able to maintain housing and the number who maintain contact with the treatment system</td>
<td>⚫ Consumer counts</td>
<td>⚫ Administrative data</td>
<td>⚫ CCBHS ⚫ MHS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>⚫ Housing status</td>
<td>⚫ Key Event Tracking (KET) ⚫ Partnership Assessment Form (PAF) ⚫ Quarterly Assessment (3M)</td>
<td>⚫ CCBHS ⚫ MHS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>⚫ Self Sufficiency Matrix (SSM)</td>
<td></td>
<td>⚫ MHS</td>
</tr>
<tr>
<td>Outreach &amp; Engagement</td>
<td>Extent to which enforcement mechanisms are used by the program, when applicable</td>
<td>⚫ AOT court involvement ⚫ Frequency and length of outreach &amp; engagement ⚫ Frequency and length of encounters ⚫ Objective of encounter ⚫ Persons participating in outreach encounter ⚫ Outcome of encounter</td>
<td>⚫ Court orders Engagement/ Encounter Log</td>
<td>⚫ CCBHS ⚫ Civil Courts</td>
</tr>
<tr>
<td>Level of Service, Participation, &amp; Retention</td>
<td>Type, intensity, and frequency of treatment of persons in the program</td>
<td>⚫ Frequency and duration of appointments Prescribed</td>
<td>⚫ Treatment plans</td>
<td>⚫ MHS ⚫ CCBHS</td>
</tr>
<tr>
<td>Area of Inquiry</td>
<td>DHCS Reporting Requirement</td>
<td>Data Element</td>
<td>Data Source</td>
<td>Responsible Agency</td>
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</tr>
<tr>
<td>Adherence/engagement to prescribed treatment by persons in the program</td>
<td>Medication possession ratio</td>
<td>Pharmacy claims</td>
<td>County health plan&lt;sup&gt;35&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Frequency and duration of appointments</td>
<td>Treatment plans Appointment schedules</td>
<td>CCBHS MHS</td>
<td></td>
</tr>
<tr>
<td></td>
<td># and % of missed appointments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The days of hospitalization of persons in the program that have been reduced or avoided</td>
<td>Hospitalizations Hospital bed days</td>
<td>Service Utilization</td>
<td>CCBHS</td>
<td></td>
</tr>
<tr>
<td>The number of persons in the program with contacts with local law enforcement, and the extent to which local and state incarceration of persons in the program has been reduced or avoided</td>
<td>Arreets Jail days</td>
<td>Sheriff’s Office, if available Local law enforcement agencies (LEAs), if available</td>
<td>Sheriff’s Office&lt;sup&gt;36&lt;/sup&gt; LEAs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sentencing</td>
<td>Criminal Courts, if available</td>
<td>Courts</td>
<td></td>
</tr>
<tr>
<td>Victimization of persons in the program</td>
<td>Victim of violence and/or abuse</td>
<td>Behavioral Health Assessment (BHA)</td>
<td>MHS</td>
<td></td>
</tr>
<tr>
<td>Violent behavior of persons in the program</td>
<td>Risk behaviors for violence o Suicide o Violent behaviors o Homicidal ideation</td>
<td>High Risk Assessment (HRA)</td>
<td>MHS</td>
<td></td>
</tr>
<tr>
<td>Substance abuse by persons in the program</td>
<td>Substance use</td>
<td>NIDA Quick Screen</td>
<td>MHS CCBHS</td>
<td></td>
</tr>
</tbody>
</table>

<sup>35</sup> Data still being negotiated.
<sup>36</sup> Data still being negotiated.
<table>
<thead>
<tr>
<th>Area of Inquiry</th>
<th>DHCS Reporting Requirement</th>
<th>Data Element</th>
<th>Data Source</th>
<th>Responsible Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social functioning of persons in the program</td>
<td></td>
<td>Participation in meaningful activities</td>
<td>Recovery Status Survey (RSS)</td>
<td>MHS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community involvement</td>
<td>Illness Management and Recover Scales (IMR)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Self Sufficiency Matrix (SSM)</td>
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<tr>
<td></td>
<td></td>
<td>Psychological functioning</td>
<td>Brief Psychiatric Rating Tool (BPRS)</td>
<td>MHS</td>
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<tr>
<td></td>
<td></td>
<td>Cognitive functioning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skills in independent living of persons in the program</td>
<td></td>
<td>Self-sufficiency</td>
<td>Recovery Status Survey (RSS)</td>
<td>MHS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Independent living</td>
<td>Illness Management and Recover Scales (IMR)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Self Sufficiency Matrix (SSM)</td>
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<tr>
<td></td>
<td></td>
<td>Level of independence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with program services both by those receiving them and by their families, when relevant</td>
<td></td>
<td>Program satisfaction</td>
<td>Consumer satisfaction survey</td>
<td>CCBHS</td>
</tr>
<tr>
<td>The number of persons in the program participating in employment services programs, including competitive employment</td>
<td></td>
<td>Involvement in employment</td>
<td>Key Event Tracking (KET) Partnership Assessment Form (PAF) Quarterly Assessment (3M)</td>
<td>CCBHS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Self Sufficiency</td>
<td>MHS</td>
</tr>
</tbody>
</table>
In addition, to reporting on the DHCS requirements, RDA will also collect data in order to answer the following two evaluation questions:

4. What are the differences in demographics, service patterns, psychosocial outcomes, and cost between those who participate in AOT without court involvement and those who participate with an AOT court order or voluntary settlement agreement?

5. What are the differences in demographics, service utilization, psychosocial outcomes, and cost between those who engage in existing FSP services and those who participate in AOT without court involvement?

Table 3 below provides information on the general areas of inquiry that RDA will explore, the data elements, the sources of data, responsible agency, as well the consumer group (i.e., FSP or AOT) that RDA will collect the data for. For additional information about the purpose of each of the assessments and for which evaluation question they will be used to answer, please refer to Appendix III. Outcome Evaluation Data Sources & Purpose. Please refer to Appendix V. Outcome Evaluation Forms and Assessments for CCBHS' behavioral health assessments and data collection forms.

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**Table 3. Areas of Inquiry and Data Information Related to Evaluation Questions Three and Four**

<table>
<thead>
<tr>
<th>Area of Inquiry</th>
<th>Data Element</th>
<th>Data Source</th>
<th>Responsible Agency</th>
<th>FSP</th>
<th>AOT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consumer Profile</strong></td>
<td>Demographics (e.g., race, gender, age, employment, etc.)</td>
<td>Demographic Forms Partnership Assessment Forms (PAF)</td>
<td>CCBHS MHS</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

37 If available. If not, KET and PAF data will be used.
## Contra Costa County Behavioral Health Services

### Assisted Outpatient Treatment Program – Evaluation Plan

<table>
<thead>
<tr>
<th>Area of Inquiry</th>
<th>Data Element</th>
<th>Data Source</th>
<th>Responsible Agency</th>
<th>FSP</th>
<th>AOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area of Inquiry</td>
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<tr>
<td></td>
<td>Area of Inquiry</td>
<td>Data Element</td>
<td>Data Source</td>
<td>Responsible Agency</td>
<td>FSP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clinical profile (e.g. diagnoses, substance use, comorbidities)</td>
<td>Quarterly Assessment (3M) Key Event Tracking (KET)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Service history (type and frequency)</td>
<td>Administrative Data</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Acuity</td>
<td>Diagnoses data</td>
<td></td>
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<td></td>
<td></td>
<td>Court involvement</td>
<td></td>
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<td></td>
<td></td>
<td>Non-court involvement</td>
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<tr>
<td></td>
<td></td>
<td>Frequency and length of outreach &amp; engagement</td>
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<tr>
<td></td>
<td></td>
<td>Frequency and length of encounters</td>
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<tr>
<td></td>
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<td>Objective of encounter</td>
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<tr>
<td></td>
<td></td>
<td>Persons participating in outreach encounter</td>
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<td></td>
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<td></td>
<td></td>
<td>Outcome of encounter</td>
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38 Data still being negotiated.
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\(^{39}\) If available. If not, KET and PAF data will be used.
\(^{40}\) If available. If not, KET and PAF data will be used.
\(^{41}\) If available. If not, KET and PAF data will be used.
As seen above in Table 2 and Table 3, RDA will rely on numerous sources of data to complete the evaluation of Contra Costa’s AOT evaluation. Below, RDA provides additional context and information for the data elements and their sources as identified in the above tables.

**Consumer Profile**

In order to examine the consumer profile of AOT and FSP consumers, RDA will utilize the demographic and administrative forms implemented by CCBHS and Mental Health Systems. In addition to using historical service provision data, RDA will also collect information on the service history records of consumers. This service history will help to paint a picture of the types of services that FSP and AOT consumers used prior to service enrollment, including mental health and alcohol and drug services. Furthermore, RDA will receive clinical data, such as diagnoses and co-morbidities, to assess the types of consumer diagnoses present in each group as well as level of acuity. For AOT consumers, RDA will also utilize the Behavioral Health Assessment (BHA) implemented by Mental Health Systems that includes background information on AOT consumers and administrative data from CCBHS.

**Outreach and Engagement**

Under this area of inquiry, the data collected will help RDA with examining the outreach and engagement processes and how it unfolds. This will help the evaluation team to better understand who is involved in the outreach and engagement process. In addition, it will explore engagement in terms of the type of outreach and engagement; the frequency, intensity, and location of outreach and engagement services; and outcomes of the outreach and engagement process. The Care Team will utilize an engagement/encounter log to gather the information described above. This information will also help RDA explore what types of consumers might benefit from different forms and lengths of engagement.

Additionally, RDA will conduct qualified requestor interviews with non-family member requestors (family member interviews are conducted under the fidelity assessment), which will allow RDA determine the extent to which requests for petitions are occurring as intended by the AOT program. These interviews will reveal the types of documentation requestors rely upon and experiences encountered by requestors’ that lead them to request an individual receive AOT services. These interviews will also develop an understanding of strengths and challenges associated with the AOT request for petition process, as well as develop insights into the ways current processes could be improved from the perspective of qualified requestors. See Appendix VI. Qualified Request Protocol for the types of questions that RDA will ask requestors.

**Level of Service, Participation, and Retention**

Within this area of inquiry, RDA will use the collected data to examine whether consumers are participating in their services and the types of services they are participating in. In addition, the evaluation team will explore the lengths and frequencies of services, and whether consumers remain retained in services and for how long. RDA will rely on administrative and service/treatment provision data collected by Mental Health Systems and CCBHS for this area of inquiry.
The program model predicts that those receiving services through the AOT program will experience decreases in hospitalizations over the program period. It also predicts that medication and treatment plan adherence will improve, and that a reduction in criminal justice system involvement will occur. To gain further information on the consumer experience, RDA will also explore consumers’ access and utilization patterns of services, as well as changes in other mental health and criminal justice services (e.g., psychiatric hospitalizations, arrests and time spent in jail, etc.). The RDA evaluation team will rely on EHR data from CCBHS for consumers’ historical service history information, as well as data from the Sheriff’s office or local law enforcement agencies (LEAs) to examine changes in criminal justice service utilization.

RDA will use these data to examine utilization patterns for AOT consumers (evaluation question two). In addition, RDA will assess differences between those who participate in AOT without court involvement and those who participate with an AOT court order or voluntary settlement agreement (evaluation question three). Lastly, the evaluation team will explore differences between those who participate in FSP programs those who participate in AOT without court involvement (evaluation question four). If needed, RDA will use the Level of Care Utilization System (LOCUS) assessment to examine utilization patterns (for evaluation questions two and three).

Outcomes for the purposes of this evaluation and area of inquiry refer to psychosocial outcomes (i.e., substance use, independent living, etc.) as well as criminal justice involvement, hospitalization, and consumer satisfaction. Below, RDA explains the data elements and sources to be utilized to measure changes in psychosocial, criminal justice, and consumer satisfaction outcomes as a result of the AOT program.

Psychosocial Outcomes

As part of CCBHS AOT program, Mental Health Systems and CCBHS will utilize numerous evidence-based psychosocial and mental health assessments. The AOT program predicts that psychosocial outcomes will improve for AOT consumers. Each of these assessments provide different information to examine changes in psychosocial outcomes. Therefore, RDA will explore utilizing each of the assessments to determine changes in psychosocial outcomes among AOT and FSP consumers, including:

- **Violent Behavior** is behavior that causes physical or emotional harm to others. It can range from verbal abuse to physical harm to self, others, or property. In order to examine this outcome RDA will rely primarily on the High Risk Assessment (HRA), which focuses on examining risk of suicide, violent behaviors, and homicidal ideation among AOT consumers. FSP consumers do not have similar information collected.

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42 If available. If not, KET and PAF data will be used.
Substance Use as defined by the Diagnostic and Statistical Manual of Mental Disorders identifies substance use disorders as the recurrent use of alcohol and/or drugs that cause clinically and functionally significant impairment. In order to examine this outcome, RDA will make use of the NIDA Quick Screen and NIDA Modified Assist information collected from AOT consumers. Substance use information for FSP consumers is limited to yes or no questions as collected on the Quarterly Assessment (3M).

Social Functioning is the ability of a person to engage in social interactions, interpersonal relationships, and activities of meaningful engagement within communities. For the purposes of this evaluation, RDA will utilize the Recovery Status Survey (RSS) and Illness Management and Recovery Scales (IMR) to examine changes in level of functioning of AOT consumers. For FSP consumers, CCBHS does not use similar assessments across all FSP programs.

Independent Living is the ability of persons to adequately and with limited assistance partake in activities of daily living such as cooking, showering, etc. For this evaluation, RDA will use the Self-Sufficiency Matrix (SSM) and Illness Management and Recovery Scales (IMR) to assess independent living and self-sufficiency outcomes for AOT consumers. Similar to the social functioning data element, CCBHS does not utilize similar assessment across all their FSP programs.

Engagement in Care is how consumers participate in services and their level of retention in programs and/or services. RDA will utilize the Level of Care Utilization System (LOCUS) to examine the level of engagement and frequency of treatment of AOT and FSP consumers.

Psychological Changes are changes in the mental and cognitive functioning of mental health consumers. In this evaluation, RDA will use the Brief Psychiatric Rating Tool (BPRS) to examine psychological and cognitive changes for AOT consumers. For FSP consumers, CCBHS FSP providers do not utilize a similar assessment.

Employment are changes in the level of and type of employment among mental health consumers. It will explore items such as types of employment received (e.g., competitive employment, supported employment, etc.) and other meaningful work experience (e.g., volunteer positions). RDA will use the Partnership Assessment Forms, Key Event Tracking form, and Quarterly Assessments to examine changes for both AOT and FSP consumers.

Education are changes in educational attainment. RDA will utilize information collected on the Partnership Assessment Forms, Key Event Tracking form, and Quarterly Assessment to examine these changes for both AOT and FSP consumers.

Housing are significant changes in the nature and status of housing situations. The evaluation team will explore items such as consumers living situations (e.g., are they housed in residential programs, apartments/homes, shelters, etc.). RDA will use the Partnership Assessment Forms,
Key Event Tracking form, and Quarterly Assessments to examine these changes for both AOT and FSP consumers.

As noted above, these assessments will assist in examining changes at the individual consumer level, which is relevant given that the AOT program expects improvements in psychosocial outcomes over time. As such, RDA will rely on the participant-level data collected from these assessments in order to explore if improvements have occurred.

Although each of the assessments have their main primary purpose, there is overlap in what each assessment measures. Therefore, RDA will explore using subsections of the assessments to examine other psychosocial outcomes, if needed. Primarily, RDA will use the assessment data to examine the psychosocial outcomes of AOT consumers (evaluation question two) and to assess if any differences exist between consumers engaged with and without court involvement, as well as by level and frequency of engagement (evaluation question three). As seen above, psychosocial outcomes for FSP consumers are limited and where possible RDA will explore triangulating data from other sources of information.

Criminal Justice Involvement and Hospitalization

In addition to improvements in psychosocial outcomes, CCBHS’s AOT program also expects reductions in criminal justice involvement and hospitalization among AOT consumers. In order to measure the expected impacts of the AOT program on criminal justice and hospital outcomes, RDA will rely on data from the Sheriff’s Office and LEAs, if available, and CCBHS. RDA will use the Sheriff’s Office and LEAs data to examine the contacts, arrest and jail-related information of consumers and CCBHS data for hospitalization, if available.

If data are not available from these two sources, RDA will rely on self-reported data from the Partnership Assessment Form (PAF), Quarterly Assessment (3M), and Key Event Tracking (KET) for FSP and AOT consumers. RDA will use these data to examine differences in outcomes between those who participate in AOT without court involvement and those who participate with an AOT court order or voluntary settlement agreement (evaluation question three) and differences between those who participate in FSP programs versus those who participate in AOT without court involvement (evaluation question four).

Consumer Satisfaction

Furthermore, the outcome evaluation will also examine consumer satisfaction through a consumer satisfaction survey. Mental Health Systems will administer the survey to consumers and their families/caregivers. The purpose of the 15-minute survey is to gather input regarding their experience and satisfaction with AOT. RDA will use the survey to examine changes in satisfaction for all AOT consumers (evaluation question two), examine satisfaction between engagement mechanisms, court involvement or non-court involvement (evaluation question three).
Costs of Services

In addition to using data to measure individual-level outcomes, RDA will collect information to examine costs at a systems-level. RDA will rely on billing claims data from CCBHS and the AOT program budgets to determine the costs of the program’s mental health services. This includes information on the costs of services provided through the AOT and FSP programs, as well as costs of all other mental health services, including hospitalizations, prescription medication costs, conservatorship, and other behavioral health services.

In addition, the evaluation team will explore utilizing data from criminal justice partners, if available, to examine changes in cost related to criminal justice involvement:

- **Criminal justice system costs**, which include criminal court proceedings, county jail day, arrests, law enforcement intervention, and transportation (police and ambulance) costs, if available.
- **Non-mental health services costs**, which include the civil court costs of the AOT program (e.g., courts, public defender, and county counsel).

Analytic Framework

RDA will provide CCBHS with comprehensive mixed methods analyses that complies with DHCS reporting requirements and responds to this evaluation’s four (4) areas of inquiry. In this section of the evaluation plan, RDA identifies the types of comparisons and analyses that the evaluation team will perform and the purpose of these analyses.

Fidelity Assessment Analysis (Research Question #1)

As noted previously, a component of the evaluation is to explore the implementation of the service delivery model, ACT, in Contra Costa County. With the assessment, RDA intends to answer evaluation question one: “How faithful are ACT services to the ACT model?” By examining this implementation fidelity of Contra Costa County’s ACT services, the evaluation will assess if ACT services are being provided as shown effective by its current evidence base.

As noted above, RDA will implement the ACT Fidelity Scale, developed at Dartmouth University, and codified in a toolkit for ease of administration. This standardized assessment provides individual, numerical ratings for 28 criteria across three domains (e.g., Human Resources, Organizational Boundaries, and Nature of Services) and also results in a composite score. The ACT Fidelity Assessment has a clearly defined approach that includes two (2) qualified assessors engaging in a series of activities that include chart reviews, observations, interviews, and focus groups to assess fidelity as well as individual scoring of each criteria and a meeting to develop consensus for the final ratings. RDA will

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

score, from one (not fully implemented) to five (fully implemented), each of the 28-program specific items in the ACT Fidelity Scale.

After scoring each item, RDA will then develop a composite score by adding each of the 28 scores together (total possible score of 140). Based on the composite score, RDA will assess level of ACT implementation. The Fidelity Scale identifies a score of 114-140 as good implementation, 85-112 as fair implementation, and a score of 84 or below as not an ACT program. Although scores of 84-112 are considered fair implementation, the farther the score is from 140 (the highest possible score) the less reliable consumer outcomes become, which then may impact the outcome evaluation findings.

The ACT Fidelity Assessment also results in clear and targeted recommendations to increase fidelity, thereby improving the likelihood that the program will achieve expected outcomes.

AOT in Contra Costa County – Outcome Analysis (Research Question #2)

Another component of the evaluation is to analyze AOT consumer outcomes, including all DHCS-required outcomes, for people participating in AOT in Contra Costa County regardless of court involvement. With this analysis, RDA seeks to answer research question two, “What are the outcomes for people who participate in AOT, including the DHCS-required outcomes?”

In exploring research question two, RDA will support the County’s local and state objectives to understand the outcomes of AOT participants, as DHCS requires each County who adopts and implements AOT to report on specific outcomes. RDA has categorized the DHCS reporting requirements into five categories: Consumer Profile; Outreach & Engagement; Level of Service, Participation, & Retention; Outcomes; and, Cost. In answering research question two, RDA will examine AOT outcomes across each of these five categories.

Consumer Profile: One of the goals of the evaluation is to gain a better understanding of who the AOT consumer population is, including their demographics, service history, level of need, and mental health status and behaviors. Although the AOT program intends to serve those with severe and persistent mental illness, there will be variations in who participates in services. By understanding these variations, CCBHS will be able to better target outreach and engagement strategies.

Analysis Strategy: The evaluation team will calculate basic frequencies and percentages to examine the specific attributes of AOT consumers such as race/ethnicity, gender, housing, education, income, clinical profile (e.g., primary diagnosis, presence of co-occurring substance abuse disorder, etc.), and service history. In addition, the evaluation team will analyze means, medians, standard deviations, and ranges to examine participants’ ages and other variables of interest such as behavioral health and substance use scores from assessments.

Outreach & Engagement: Another goal of this evaluation is to better understand which consumers require different forms and durations of outreach as well as different mechanisms of program engagement. During outreach and engagement, some consumers will elect to participate voluntarily, while other may require additional engagement or other mechanisms of engagement (i.e., court
involvement). To further our understanding of these different groups, RDA will assess differences in consumer profiles by court involvement, as well as differences in levels and duration of outreach and engagement. RDA will assess these differences at the individual and programmatic levels to help better understand the extent to which the outreach process and enforcement mechanisms are used to generate program engagement.

**Analysis Strategy:** RDA will maintain up-to-date outreach and engagement data in the AOT flow chart to describe the number of individuals who engage in AOT at different points in the outreach and engagement process, including with or without court involvement. In addition, RDA will assess the consumer profiles of each population in order to identify systematic differences in the consumer profiles of the various service populations.

**Level of Service, Participation, & Retention:** There will also be variations in the levels of services that consumers will receive, as well as their levels of participation and retention. In order to continue better understanding consumers and their needs, the evaluation team will examine the types, frequencies, and durations of services and programs that they access and then utilize. Furthermore, the evaluation team will explore the levels of participation and retention in program services as well as compare and contrast consumer profiles with levels of outreach and engagement.

**Outcomes:** AOT is designed to improve the behavioral and mental health, as well as overall wellbeing of consumers over the duration of the program. In addition, AOT aims to reduce criminal justice involvement and hospitalization. While some consumers may require different mechanisms of engagement into AOT (i.e., court involvement vs. no court involvement) and different levels of service, all AOT consumers should show improvements in psychosocial outcomes, criminal justice involvement, and hospitalization. The evaluation will explore how engagement mechanisms and levels of services and participation relate to improving outcomes.

**Cost:** An important aspect and expectation of the AOT program is that it will reduce the need for utilizing costly services such as psychiatric emergency services, hospitalizations, and the criminal justice system. Multiple systems and departments within counties incur these costs for persons with serious mental illness, including departments of behavioral health, health and human services agencies, and justice. Furthermore, some of these costs are also more expensive than others; for example, psychiatric hospitalizations are costlier than outpatient treatment. Also exacerbating the problem are the high levels of repetitive services utilized, which produces an even greater cost to local county governments and subsequently to State governments as a whole. The County wishes to examine to what extent AOT changes the costs and fees for services for those in the program. This information will support the County in assessing their return on investment for the AOT program.

**Analysis Strategy:** To explore outcomes among AOT consumers, including changes in service engagement and retention as well as costs associated with ACT service provision and criminal justice involvement, RDA will employ a pre-/post-test experimental design and perform repeated measure ANOVA’s every six months for the duration of the evaluation period. Before now, Contra Costa County has not had an AOT program; therefore, RDA will use consumer data collected before and at the onset
of AOT implementation to make within-consumer comparisons of DHCS outcomes over time. In other words, RDA will use each consumer’s previous service history (before enrollment into AOT) to establish his/her baseline-level of data and then analyze changes in service engagement and retention patterns over time, as well as changes in other outcomes including psychosocial functioning, well-being, and costs associated with ACT service provision and criminal justice involvement from baseline to follow-up.

Using consumer-level scores on various DHCS outcomes and data collected over time, RDA will use repeated measures analyses to assess whether changes in AOT consumer outcomes are meaningful. For example, the AOT program will collect life skills information through the Self-Sufficiency Matrix (SSM) tool starting at the initial screening and during follow-up. A repeated measures linear regression analyses would then answer the question: is there a change in SSM scores for consumers across time spent in the AOT program? These types of analyses allow the evaluation to address time-dependent (e.g., length of time in program) and time-independent (e.g., gender, clinical profile, etc.) variables in advanced statistical models. These methods help to better assess changes in outcomes over time and to control for potential confounding factors, allowing for a robust interpretation of the results and confidence in stating that participation in AOT is the reason for the outcomes achieved by consumers, as opposed to being caused by other external factors.

AOT with and without Court Involvement - Comparative Analysis (Research Question #3)

As discussed earlier, there are significant gaps in the literature about the effectiveness of AOT as compared to voluntary programs. This evaluation seeks to inform the current research assessing the conditions under which AOT is most effective by answering research question three, “What are the differences in demographics, service patterns, psychosocial outcomes, and cost between those who participate in AOT without court involvement and those who participate with a court order or voluntary settlement agreement?” Exploring the variable of court involvement in engaging persons with serious mental illness into intensive mental health services is crucial to understanding the major intentions underlying court involvement in the AOT engagement process.

Consumer Profile: RDA will assess differences in the consumer profiles of those who engage in AOT prior to court involvement through the outreach and engagement process versus those who only engage after court involvement in Contra Costa County. By gaining a better understanding of the consumer profiles of those who are more likely to engage in services with and without court involvement, this analysis will help inform the County of how to best target outreach and engagement efforts in the future.

Analysis Strategy: For categorical variables, RDA will use chi-square measures of association or Fisher’s exact tests (when low sample sizes) to examine differences between voluntarily engaged consumers and consumers who engaged in services after court involvement. For continuous variables, such as age or behavioral health scores, RDA will utilize independent sample t-tests to examine differences between the groups (i.e., court involvement vs. no court involvement).
Outreach & Engagement: For this component of the evaluation, RDA will assess the effects of different AOT engagement mechanisms (i.e., court involvement vs. no court involvement) on AOT consumer outcomes as well as the differences in location, frequency, and intensity of outreach encounters. The engagement mechanism is the critical independent variable of interest in this analysis, as this evaluation seeks to gain a stronger understanding of the consumer profiles, service patterns, outcomes, and costs associated with court-involved AOT participation compared to non-court-involved AOT participation.

Level of Service, Participation, & Retention: RDA will assess differences across several outcomes between those who participate in AOT with and without court involvement to determine whether court involvement plays an additional role in improving DHCS outcomes within Contra Costa County. This evaluation will examine whether there are differences in patterns of treatment adherence and retention in the AOT program in order to determine whether court involvement serves as a mechanism for increasing service intensity and frequency, adherence, and retention in Contra Costa County's mental health services. This will help inform the County of what populations might be most likely to benefit from court-involved services provision in the future.

Outcomes: RDA will assess whether individuals who participate in AOT with and without court involvement have disparate psychosocial outcomes and levels of criminal justice involvement and hospitalization over the evaluation period. In doing so, we will maintain focus on identifying for which populations, under what conditions, AOT produces positive outcomes in order to help identify under what circumstances AOT is most effective.

Cost of Services: Finally, RDA will analyze differences in the costs of service provision and criminal justice involvement for individuals who participate in AOT with and without court involvement in order to determine whether court involvement is a cost-effective mechanism of service engagement for the County.

Analysis Strategy: RDA will use repeated measures ANOVA’s and regressions to examine patterns of service engagement and retention, as well as changes in psychosocial outcomes, criminal justice involvement, and hospitalization over the course of the evaluation period for AOT consumers with and without court involvement. As noted above, these analysis techniques will allow RDA to address time-dependent and time-independent variables in advanced statistical models that allow for the isolation of the impacts of court involvement on outcome variables of interest.

If necessary, RDA will use the propensity score weighting (PSW) methodology in order to address potential selection bias - a critical tenant in research studies - of consumers’ non-random assignment to receiving AOT with or without court involvement. PSW will help account for systematic differences in the baseline characteristics of those who choose to participate in AOT with and without court involvement, which helps alleviate the concern of consumer’s own decision-making (i.e., no court involvement vs. court involvement) potentially skewing findings.
AOT versus FSP - Comparative Analysis (Research Question #4)

FSP is a modified version of ACT, which is the service delivery model being used for all AOT participants. In order to assess the effectiveness of AOT (regardless of court involvement) versus traditional FSP services (an established mental health service model in Contra Costa County for individuals with severe mental illness), RDA will examine research question four, “What are the differences in demographics, service utilization, psychosocial outcomes, and cost between those who engage in existing FSP services and those who participate in AOT with no court involvement?

This research question compares the group of people participating in AOT, regardless of court involvement, with those participating in FSP services. In order to answer research question four, RDA will perform comparative analyses that are very similar to the analyses performed for research question three; the critical difference is that RDA will compare all AOT participants regardless of court involvement with FSP participants in order to assess the effectiveness of AOT versus FSP in Contra Costa County. This question is intended to examine the addition of AOT and ACT into the existing system.

Consumer Profile: RDA will assess the differences in the consumer profiles between those who engage in FSP services and those who are unable to do so and thus are engaged in AOT instead. By gaining a better understanding of the consumer profiles of those who are more likely to engage in FSP services versus AOT, this analysis will help inform the County of how to best target outreach and engagement efforts in the future.

Analysis Strategy: For categorical variables, RDA will use chi-square measures of association or Fisher’s exact tests (when low sample sizes) to examine differences between FSP and AOT consumers. For continuous variables, such as age or behavioral health scores, RDA will utilize independent sample t-tests to examine differences between the two populations.

Outreach & Engagement: For this component of the evaluation, RDA will assess differences in consumer outcomes for individuals with serious mental illness who seek-out FSP treatment compared to those who engage in AOT treatment through the outreach and engagement process (regardless of court involvement). FSP versus AOT participation is the critical variable of interest in this analysis. This evaluation seeks to gain a stronger understanding of the consumer profiles, service patterns, outcomes, and costs associated FSP versus AOT participation.

Level of Service, Participation, & Retention: RDA will assess differences between the FSP and ACT service delivery models, maintaining focus on identifying disparate services that are offered as well as differences in patterns of treatment adherence and retention across programs. Given that both models are intended to serve similar populations with a flexible, interdisciplinary team, this research question will also explore the differences in service frequencies and intensities of FSP services as compared to ACT. In doing so, RDA will pay special attention to identifying the specific populations and particular conditions for which AOT participation serves to increase intensity and frequency of service, adherence, and retention in program services. This will help inform the County of who might be most promising to engage in AOT in the future.
Outcomes: RDA will assess whether individuals who participate in FSP versus AOT have disparate psychosocial outcomes and levels of criminal justice involvement and hospitalization over the evaluation period. In doing so, the evaluation will maintain focus on identifying the particular populations and conditions for which AOT participation produces more positive (or negative) outcomes than FSP. Given the potential differences in persons served and actual services provided, there may also be differences in outcomes experienced between these two groups that may inform modifications to future services designs and/or treatment assignments.

Cost of Services: RDA will also analyze differences in the costs of service provision and criminal justice involvement for individuals who participate in FSP versus AOT in order to assess whether AOT is a cost-effective mechanism for helping to generate service engagement in the County.

Analysis Strategy: RDA will use repeated measures ANOVA’s and regressions to examine patterns of service engagement and retention, as well as changes in psychosocial outcomes, criminal justice involvement, and hospitalization over the course of the evaluation period for FSP versus AOT consumers. As noted previously, these analysis techniques will allow RDA to address time-dependent and time-independent variables in advanced statistical models that allow the evaluation to isolate the impacts of FSP versus AOT service engagement.

RDA will explore the possibility of utilizing a matched random sample of FSP consumers and AOT consumers to explore differences in psychosocial outcomes, criminal justice involvement, and hospitalization by service history, clinical profile, and demographics. This would allow the evaluation to compare and contrast the outcomes produced by the two program models (FSP vs. AOT). In this process, RDA would develop a pool of FSP consumers (controls) and a pool of AOT consumers (cases) that have serious mental illness. From these two pools, RDA would match consumers that are similar in their service histories, clinical profile, and demographics and then randomly select consumers to include in the analysis. By using a matched random sample, RDA can more effectively explore how the different program models (FSP vs. AOT) are related to observed outcomes.

Potential Limitations to the Evaluation

As with any evaluation or research project, limitations do exist. This is particularly evident in evaluations such as this one that takes place in natural settings rather than in a randomized-controlled trial (which are often identified as the gold standard in research communities). Although RDA identified the intended objectives of this evaluation above, the potential findings may change depending on the implementation of AOT in Contra Costa County, data availability, and the sample sizes of persons engaging in AOT with and without court involvement.

As noted earlier, the evaluation team cannot predict how consumers will engage with the courts as a result of AOT, which would limit the types of comparisons that RDA can make between consumers who participate in AOT without court involvement and those who participate with a court order or voluntary settlement agreement.
In similar fashion, discussions with AOT stakeholders have alluded to difficulties in receiving criminal justice related data from the 15 law enforcement agencies across Contra Costa and county agencies. To this end, RDA and CCBHS are still exploring what criminal justice data may be available. However, due to the limited ability of the Sheriff’s Office being able to query their data on an individual-level basis, the evaluation team and AOT partner may have to explore manual data pulls, which again may severely limit access to data. If the evaluation team is unable to receive data from any of the criminal justice partners, RDA will rely on self-reported data collected as part of CCBHS’s standard of care for mental health consumers.

In addition, limitations may exist in the cost analysis as the evaluation team may have to rely on average cost information, rather than actual per service cost information. Although not ideal, using the average cost, which may be readily available, still provides an estimation to the level of cost and potential savings of the AOT program that may not otherwise be achievable.

Additionally, FSP programs in Contra Costa County operate under different service levels, with some providing more clinical support, while others provide more case management services. Moreover, psychosocial and recovery measures are not collected in the similar fashion between AOT consumers and FSP consumers. Due to this fact, comparisons across the two consumer populations (AOT and FSP) may be difficult. Also exploring changes in assessments and behavioral health scores may also be limited. Nevertheless, the evaluation team will have access to data in relation to utilization of psychiatric emergency services, hospitalizations, and length of time spent in the hospital across all three groups. The evaluation team will use these as proxies for consumer behavioral health improvement as the program expects to reduce overall use of these services, as well as reducing the duration of hospital stays.

In light of the potential limitations, there is value in having research results from less tightly controlled real world settings such as this evaluation. By studying the implementation of AOT in Contra Costa County’s behavioral health system, this evaluation will help to understand how mental health professionals, consumers, and their environments influence sustainable uptake, adoption, and implementation of AOT. This evaluation would not be able to answer such questions if implementation of AOT took place under tightly controlled protocols and implementation. This real world evaluation will provide answers to critical questions that will assist Contra Costa County in improving their mental health services to meet the needs of those with high need as well as examine AOT’s impacts on the current systems of care in the County.

**Monitoring and Oversight of Evaluation**

Throughout the evaluation, RDA will work with CCBHS in the monitoring and oversight of the evaluation activities. With support from CCBHS, RDA will facilitate planning meetings with representatives from participating agencies to discuss approaches to evaluation. We are aware that there are different data sharing requirements for criminal justice and behavioral health data, and we will work to ensure that the evaluation meets legal requirements for sharing of data. Additionally, in collaboration with the AOT
stakeholders, RDA will discuss the implications of using different types of data for different analytic approaches and subsequent findings. The evaluation team, in collaboration with AOT partners, will be responsible for the management and monitoring of all evaluation-related activities. The group of AOT partners will include:

- Contra Costa Behavioral Health Services;
- Mental Health Systems; and
- Justice partners: County Counsel, Superior Court, Public Defender’s Office.

The evaluation team and the AOT partners will:

- Contribute their knowledge and expertise to the evaluation design, interpretation of results, and development of lessons learned and recommendations;
- Ensure that the voices of those most impacted by the mental health systems are meaningfully included at every stage of the evaluation process; and
- Strengthen shared learning throughout the project.

In addition, after data are collected and findings developed, RDA will report these findings for consultation first with the AOT partners. After these meetings, the evaluation team will then report and discuss findings with Contra Costa’s Mental Health Commission, followed by discussions with the Family and Human Services Committee of the Board of Supervisors as well as the full Board of Supervisors (if requested by the F&HS Committee).

**Training AOT Staff to Collect Evaluation Information**

The evaluation team will conduct meetings with AOT partners to help ground them in the evaluation and identify the data needed to ensure a successful evaluation. Meeting topics will cover topics such as:

- Types of clinical assessment tools
- Use and frequency of clinical assessment tools
- Collecting and entering data into EHR

Meetings will familiarize AOT partners with the evaluation’s and DHCS requirements. The meeting objectives will be for AOT stakeholder to understand:

- The DHCS requirements
- What information needs to be collected
- What data needs to be shared
- The evaluation approach RDA will implement

**Ongoing Technical Assistance**

Over the course of the evaluation, the RDA evaluation team will provide AOT partners with technical assistance and address questions relating to data collection and reporting activities. RDA will provide technical assistance and troubleshooting during regular meetings or phone calls and during fidelity-
assessment site visits. RDA will note and discuss any discrepancies in data quality with the CCBHS staff leads in order to develop solutions.

The evaluation team will also be available in an “on-call” basis remotely through phone and email communication in order to address technical assistance requests from CCBHS and MHS staff. If deemed necessary, RDA will also utilize alternative methods of communication for the evaluation to communicate with CCBHS and MHS staff, such as video conferencing and using remote desktop platforms.

**Timeline**

The CCBHS AOT evaluation is a four-year project that will take place from December 1, 2015 through June 30, 2019. Each year of this project is comprised of four quarters with Year 1 Quarter 1 starting on December 1, 2015. Error! Not a valid bookmark self-reference. below provides an outline of evaluation activities over a standard 12-month year beginning in December. RDA expects that this schedule will repeat each year for the entire four-year evaluation period, with the exception of evaluation planning activities which shall take place solely in year one. The State of California requires that counties report on the DHCS requirements annually in May for consumers receiving court-ordered services. RDA shall analyze data and draft the main and final evaluation report one time in the final year of the evaluation (June 2019). The evaluation team understands that program needs develop and evolve, so it will be flexible in adapting the evaluation timeline to align with CCBHS’ needs. RDA will confer with CCBHS leadership when creating any modifications to the evaluation timeline.
Table 4. Contra Costa County ACT/AOT Evaluation Timeline

<table>
<thead>
<tr>
<th>Evaluation Activity</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
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<tr>
<td></td>
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<td>F</td>
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<td>O</td>
<td>N</td>
<td>D</td>
<td>J</td>
</tr>
<tr>
<td>Evaluation Planning</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Review of Data Sources</td>
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<tr>
<td>Evaluation Plan Development</td>
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<tr>
<td>Presentation of Evaluation Plan</td>
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<td></td>
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<tr>
<td>Finalization of Evaluation Plan</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Data Collection</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Collection and Analysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key Informant Interviews</td>
<td></td>
<td></td>
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<tr>
<td>Focus Groups</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Fidelity Assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Department of Health Care Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting</td>
<td></td>
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</tr>
<tr>
<td>Final Evaluation Reporting</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Technical Assistance and Communication</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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Appendix I. Program and Evaluation Logic Models

Figure 2. Contra Costa County ACT/AOT Program Logic Model

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcomes</th>
<th>Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding sources: AB1421, MHSA, Medicaid/Medicare, Private insurance, Self-pay</td>
<td>Start-up</td>
<td>Start-up</td>
<td>Participant-level</td>
<td>Model is used to address the needs of consumers with serious mental illness who are not currently engaged in services</td>
</tr>
<tr>
<td>CCBHS, MHS staff, ACT/AOT program staff</td>
<td>Eligibility criteria and identify eligible participants (existing and incoming)</td>
<td>Ongoing, regularly scheduled ACT meetings attended by all appropriate stakeholders</td>
<td>Improved access to treatment and services</td>
<td>ACT/AOT increases overall wellbeing and quality of life of consumers</td>
</tr>
<tr>
<td>Administrative staff, other staff</td>
<td>Hire and assemble ACT/AOT team</td>
<td>List of community resources and partners</td>
<td>Increased coordination &amp; integration of services</td>
<td>ACT/AOT improves CCBHS quality of care and scope to better align with consumers needs</td>
</tr>
<tr>
<td>Existing relationships and agreements with Contra Costa County service providers</td>
<td>Develop ACT/AOT Training Plan and materials</td>
<td>Lists of eligible participants</td>
<td>Improved health outcomes &amp; treatment compliance</td>
<td>Knowledge gains resulting from this program are disseminated throughout the County and State</td>
</tr>
<tr>
<td>Electronic Health Records</td>
<td>Revise outreach/engagement, intake and screening procedures</td>
<td>Lists of participants referred, screened, selected and engaged</td>
<td>Increased consumer satisfaction</td>
<td>Decreased per capita costs of behavioral health and criminal justice care</td>
</tr>
<tr>
<td>Facilities &amp; supplies: Medical exam rooms, labs, group rooms</td>
<td>Identify and develop office space</td>
<td>ACT staff hired</td>
<td>Increase access to services for unmet needs</td>
<td></td>
</tr>
<tr>
<td>Public Defender, District Attorney’s, Judges, other criminal justice staff</td>
<td>Develop informational and outreach/engagement materials</td>
<td>ACT staff trained in ACT procedures and workflow</td>
<td>Improved well-being</td>
<td></td>
</tr>
<tr>
<td>Court rooms, court documents, court orders</td>
<td>Develop referral system, strengthen relationships with referral agencies</td>
<td>Implementation</td>
<td>Reduced hospitalizations</td>
<td></td>
</tr>
<tr>
<td>Contract Evaluators</td>
<td>Inform consumers, family/caregivers, stakeholders about ACT/AOT and processes</td>
<td>Consumers, family, CCBHS provide referrals</td>
<td>Decreased criminal justice involvement</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ACT Care Team conducts outreach/engagement</td>
<td>Enhanced integration of services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consumers voluntarily engage in services or proceed through AOT court procedures</td>
<td>Increased collaboration among staff</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Referral networks and channels functioning</td>
<td>Increased collaboration between partners (e.g. CCBHS and Public Defenders)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ACT Care Team develops treatment and case plans</td>
<td>Changes in treatment plans</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>MOUs &amp; agreements in place with courts and other relevant parties</td>
<td>Improved case management</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consumers enroll and receive services</td>
<td>Improved treatment plans</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consumers receive voluntary settlement agreements or AOT court-orders, if needed</td>
<td>Reduced costs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Treatment and case plans developed and revisited</td>
<td>Reduced service repetition</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consumer visit indicators: # of consumers, size of waitlist, average time on waitlist, length of outreach/engagement, # of encounters, #/types of services, attendance, adherence to treatment</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Medications &amp; changes in medications</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Consumer demographics</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Natural supports for participants</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>ACT/AOT trainings</td>
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<td></td>
</tr>
</tbody>
</table>
Figure 3. Contra Costa County ACT/AOT Evaluation Logic Model

**PROCESS**

### Inputs
- Evaluation Questions
  - Are the resources adequate?

### Activities
- Evaluation Questions
  - Have the activities been implemented as planned? If not, why? What were barriers and how were they addressed?

### Outputs
- Evaluation Questions
  - How did the ACT/AOT model:
    - Recruit and retain ACT staff?
    - Refer and engage consumers?
    - Improve access to services?
    - Provide services?
    - Who did the model engage?
    - Who did the model refer to AOT courts?

### Evaluation Questions
- **What will be measured?**
  - Was budget spent according to plan?
  - How was the budget adjusted and why?
  - Did the project require additional resources which were not budgeted for?
  - Were contracts developed with service providers, and evaluators?
  - Were staffing goals met?

### Methods
- Review of budget and expenditures (end of each fiscal year)
- Interviews with ACT staff

### Methods and Timeline
- Interviews with leadership, ACT Care Team, program staff (annual)
- ACT Fidelity Assessment (annual)
- Client activity reporting (monthly)

### Evaluation Questions
- **What will be measured?**
  - Demographic information on ACT consumer population
  - # visits/services
  - # / % of ACT consumers engaging voluntarily or through court procedures
  - # treatment/case plans developed; how were they developed
  - Staff to ACT consumer ratios
  - Consumer and family experience
  - Leadership and ACT/AOT staff experience in implementing ACT/AOT

### Evaluation Questions
- **What will be measured?**
  - Changes in consumer well-being and health outcomes
  - Changes in health and wellbeing metrics (including life skills, functioning, mental health scores) for ACT consumers
  - Changes in criminal justice metrics
  - Changes in cost

### Evaluation Questions
- **Methods and Timeline**
  - Comparison analysis (annual)
  - Cost-benefit analysis (annual)
  - Participant satisfaction survey (annual)
  - Fidelity assessment (annual)
  - Focus groups and interviews (annual)

### Evaluation Questions
- **Methods and Timeline**
  - ACT referral forms, outreach/engagement forms, court petitions (annual)
  - Consumer and family focus groups (annual)
  - Leadership and staff interviews (annual)

### Evaluation Questions
- **Evaluation Questions**
  - Did the project require additional resources which were not budgeted for?
  - Were contracts developed with service providers, and evaluators?
  - Were staffing goals met?

### Evaluation Questions
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  - Were contracts developed with service providers, and evaluators?
  - Were staffing goals met?
## Appendix II. Contra Costa County ACT/AOT Assessment Schedule

<table>
<thead>
<tr>
<th>Tool</th>
<th>Administrator</th>
<th>Intake (within 30 days)</th>
<th>60-days</th>
<th>90 days</th>
<th>6-months</th>
<th>9-months</th>
<th>Annual</th>
<th>Discharge</th>
<th>As Needed</th>
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<tbody>
<tr>
<td>Recovery Status Survey (RSS)</td>
<td>*Consumer</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Brief Psychiatric Rating Scale (BPRS)</td>
<td>PSC</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
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<tr>
<td>Self Sufficiency Matrix</td>
<td>PSC/SAI</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Illness Management &amp; Recovery Scale (IMR)</td>
<td>PSC/SAI</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>NIDA Quick Screen</td>
<td>PSC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Behavioral Health Assessment</td>
<td>PSC</td>
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<td></td>
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<td></td>
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<tr>
<td>Level of Care Utilization System (LOCUS)</td>
<td>PSC</td>
<td>x</td>
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<td>High Risk Assessment</td>
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<td>Fidelity Assessment</td>
<td>RDA</td>
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</table>
# Appendix III. Outcome Evaluation Data Sources & Purpose

## Table 6. Descriptions of Outcome Evaluation Data Sources

<table>
<thead>
<tr>
<th>Data Sources</th>
<th>Purpose</th>
<th>Evaluation Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT/AOT Stakeholder Survey</td>
<td>A survey used to measure consumer and stakeholder experience with ACT/AOT, as well as consumer and family/caregiver satisfaction.</td>
<td>2</td>
</tr>
<tr>
<td>Behavioral Health Assessment (BHA)</td>
<td>Assessment to provide information on risk of harm, employment and education history, legal information, social and family history, mental status examination, and substance use.</td>
<td>3</td>
</tr>
<tr>
<td>Cost Data</td>
<td>Used to explore cost of service provision and potential savings due to reduced hospitalizations and use of psychiatric emergency services.</td>
<td>4</td>
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<tr>
<td>Criminal Justice Records</td>
<td>Used to examine changes in criminal justice involvement.</td>
<td>x</td>
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<tr>
<td>Demographic Forms</td>
<td>Provide demographic information on consumers</td>
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</tr>
<tr>
<td>Engagement Log</td>
<td>Provide information on outreach/engagement activities</td>
<td>x</td>
</tr>
<tr>
<td>High Risk Assessment (HRA)</td>
<td>Assessment to provide information on risk of suicidal risk, violent behavior, and/or homicidal ideation.</td>
<td>x</td>
</tr>
<tr>
<td>Illness Management and Recovery Scales (IMR)</td>
<td>A 15-point scale that explores how consumers are managing their illness and gradations in changes to recovery or relapse.</td>
<td>x</td>
</tr>
<tr>
<td>Key Event Tracking (KET)</td>
<td>A CCBHS form used to examine education, employment, criminal justice issues, service utilization, and emergency intervention needs.</td>
<td>x</td>
</tr>
<tr>
<td>Level of Care Utilization System (LOCUS) 2010 Version</td>
<td>A 30-item assessment that inspects factors such as risk of harm, recovery environment, functional stress, co-morbidities, treatment and recovery history, and engagement in treatment/services.</td>
<td>x</td>
</tr>
<tr>
<td>NIDA-Modified Assist v2.0</td>
<td>An 8-question, with multiple sub-questions, screening that examines lifetime substance use and used to determine risk-levels for future substance use to develop tailored</td>
<td>x</td>
</tr>
<tr>
<td>Evaluation Plan</td>
<td>NIDA Quick Screen</td>
<td>Pharmacy Claims</td>
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<tr>
<td>----------------</td>
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<tr>
<td>support and intervention.</td>
<td>A 4-item questionnaire that asks about history of substance use in the past year used in collaboration with the NIDA Modified Assist.</td>
<td>Used to develop the medication possession ratio, which examines adherence to medication treatment.</td>
</tr>
</tbody>
</table>
Appendix IV. ACT Fidelity Assessment Packet

Mental Health Systems Data Request

Staffing

1. Roster of all ACT team staff, position, and status for the past 2 years (Example below)

<table>
<thead>
<tr>
<th>Team Member</th>
<th>Position/Role</th>
<th>Currently Employed or Date of Separation/Leave</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

2. Staff Vacancies during the past 12 months by position (Example below)

<table>
<thead>
<tr>
<th>Month</th>
<th>Vacant Positions (List)</th>
<th>Month</th>
<th>Vacant Positions (List)</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2015</td>
<td></td>
<td>July 2015</td>
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<td>February 2015</td>
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<td>August 2015</td>
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<td>March 2015</td>
<td></td>
<td>September 2015</td>
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<td>April 2015</td>
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<td>October 2015</td>
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<tr>
<td>May 2015</td>
<td></td>
<td>November 2015</td>
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<tr>
<td>June 2015</td>
<td></td>
<td>December 2015</td>
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</tr>
</tbody>
</table>
Program Documentation

1. Written admission criteria
2. ACT Program Design and/or description
3. ACT Program brochures

Consumer Information

1. List of last 10 hospital admissions (Example below)

<table>
<thead>
<tr>
<th>Identifier (Name or other identifier)</th>
<th>Admission Date</th>
<th>Discharge Date</th>
<th>Discharge Disposition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
2. Roster of ACT consumers and descriptive information for people enrolled in ACT during the past 12 months (Example below)

<table>
<thead>
<tr>
<th>Identifier (Name or other identifier)</th>
<th>Co-Occurring Disorder (y/n)</th>
<th>Living Situation</th>
<th>Contact with Informal Network (y/n)</th>
<th>Employment Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>At Intake</td>
<td>Current</td>
<td>At Intake</td>
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<tr>
<td></td>
<td></td>
<td>Current</td>
<td></td>
<td>Current</td>
</tr>
</tbody>
</table>
Contra Costa Behavioral Health Services
Assisted Outpatient Treatment Program – Evaluation Plan

Contra Costa Behavioral Health Services Data Request
For all consumers who have been enrolled in ACT over the past 12 months:

ACT Consumer Information
1. Demographics, including race/ethnicity, age, gender, zip code, and any other available variables
2. Primary diagnoses
3. % of consumers with a substance abuse diagnosis

ACT Service Information
1. Admission and Discharge dates for all ACT consumers who had an open ACT episode in the past 12 months.
2. List of individual service encounters for each ACT consumer in the past 12 months, including: RU or program name, service code/type of service, individual staff/provider, location of service, length of service.

Contra Costa Behavioral Health Services Information
1. Admission and Discharge dates for all ACT consumers for non-ACT services for 1 year prior to ACT admission through November 2015, including hospitalization, crisis residential, other residential, and any outpatient services.
2. List of individual service encounters for all ACT consumers for non-ACT services in the past 12 months, including: RU or program name, service code/type of service, individual staff/provider, location of service, length of service.
   a. Is it possible to include substance abuse programs (e.g. detox, residential, outpatient, and/or intensive outpatient)?
3. Key events for FSP programs
   a. Incarceration- Do you have any way of tracking days incarcerated?

*We will need a data dictionary for RUs and service codes.
Team Meeting Observation

# of Consumers Reviewed: ________________  % of Consumers Reviewed: ________________

Notes

Team Leader Discussion
ACT Team Staffing

1. Can you list all team members, their % FTE, and roles? What other responsibilities do team members have?
   a. **Team Leader:** How do you spend your time? What % is spent providing direct service? How do you identify where to provide direct service? What % of consumers do you provide direct service to?
   b. **Psychiatrist:** What is the role of the psychiatrist? Does he/she come to the meetings? Is he/she accessible? Does the psychiatrist ever see consumers not on the ACT team?
   c. **Nurse:** What is the role of the nurse? Does he/she come to the meetings? Is he/she accessible? Does the nurse have responsibilities outside of the ACT team?
   d. **SA Specialist:** How much experience and/or training does he/she have?
   e. **Voc/Ed Counselor:** How much experience and/or training does he/she have?
   f. **Peer Counselor:** What is the role of the peer counselor? How are consumers involved as members of the team? Are they paid? Full-time? Are they full-fledged members of the team?

2. Who has left in the past year?

ACT Team Meeting

1. How often do the staff meet to plan and review services for each consumer?
2. How many consumers are reviewed at each meeting?
3. How do you document the team meetings? (Take a look at the documentation, if available)

ACT Consumers

1. How many consumers are currently enrolled in ACT or have an “active status”?
2. In a typical week, what percentage of consumers sees more than one member of the team?

Admission

1. Does your ACT team have a clearly defined population with whom you work? What is the target population?
2. What formal admission criteria do you use to screen potential consumers?
3. How do you apply these criteria?
4. Who makes referrals to the ACT team?
5. Who has the final say about whether a consumer is served by the ACT team?
6. Are there circumstances where you have to take consumers onto the ACT team?
7. What recruitment procedures do you use to find consumers for the ACT team?
8. Do you have some ACT consumers that you feel do not really need the intensity of ACT services?

Service Provision

1. Describe your outreach process. What types of outreach do you use?
2. How do you do service planning?
3. Which of the services do you provide?
   - Psychiatry
   - Counseling/Psychotherapy
   - Housing Support
   - Substance Abuse Treatment
   - Employment and Rehabilitative Services
4. What 24-hour emergency services are available for ACT consumers? What is the ACT team’s role in providing 24-hour services? How do you staff the 24/7/365 responsibility? What other services do you refer to in a crisis?
5. For each hospital admission, what happened on this admission? Was the team aware of the admission in advance? What role did the ACT team play in the decision to hospitalize? Are any ACT team members in regular contact with the hospital? Does the ACT team policy differ from the rest of the agency regarding hospital admission?
6. For each hospital discharge, what happened on this discharge? Was the team aware of the discharge in advance? What was the% of cases in which the ACT team was involved in the decision or planning for discharge of consumers hospitalized in the last year? What role does the ACT team play in psychiatric or substance abuse discharges? Does the ACT team role in hospital discharges differ from the general agency policy?
7. How frequently does the team have contact with a consumer’s informal network?

Substance Abuse Treatment
1. How many consumers have co-occurring disorders? How many receive individual or group SUD counseling?
2. How do you manage/treat co-occurring disorders? How do you provide substance abuse treatment? What treatment models do you use?
3. What kinds of SUD counseling do you provide? What types of SUD counseling do you offer? Individual? Group?
4. Who provides SUD counseling and how do you determine the number of sessions? What types of groups are offered? Who offers them? Who attends?
5. What other resources do you access? 12-step? Detox?
6. How do you address consumers who are not willing/ready to be abstinent? Do you use hard reduction techniques? Please provide examples.
7. Are you familiar with stage-wise approaches? How does your program use this approach?

Engagement
1. Think about 2-3 consumers who have been difficult to engage.
2. What did the team do to reach out to each of these consumers?
3. Was there anything more you could have done to retain them in services?
4. What methods does the team use to keep consumers involved in ACT?
5. Which, of any, of the following methods does the team use?
Contra Costa County Behavioral Health Services
Assisted Outpatient Treatment Program – Evaluation Plan

- Rep payee services
- Outpatient commitment (AOT)
- Contacts with probation and/or parole officers
- Street and shelter outreach after a consumer is enrolled
- Others? ______________________________________

Discharge

1. Let’s review the list of consumers who have been discharged from the program in the last 12 months. How many of them have graduated because they no longer needed services? What percentage or expected to be discharged in the next 12 months? How many dropped out during the last 12 months?
2. For consumers who may have moved, what efforts did the ACT team make to connect them to services in their new location?
3. Does the team use a level or step-down system for consumers who no longer require intensive services?
Team Member Discussion

1. Can you describe your role and responsibilities on the ACT team?
2. Think of one ACT consumer.
   a. How many staff interacted with this consumer this week?
   b. How about the previous week?
   c. Is this pattern similar for other consumers?
3. Describe your outreach process. What types of outreach do you use?
4. How do you do service planning?
5. Which of the services do you provide?
   - Psychiatry
   - Counseling/Psychotherapy
   - Housing Support
   - Substance Abuse Treatment
   - Employment and Rehabilitative Services
6. What 24-hour emergency services are available for ACT consumers? What is the ACT team’s role in providing 24-hour services?
7. How often is the team involved in the decision to admit consumers for psychiatric hospitalization? Describe the process the team goes through when consumers must be admitted to a hospital? How often is the team involved discharge planning when consumers are hospitalized for psychiatric or substance abuse reasons?
8. What percentage of your contacts with consumers are in the community and what percentage are office based?
9. How often do you close cases because consumers refuse treatment or you lose track of them? What factors does the team consider when closing a case?
10. What happens if a consumer says they don’t want your services?
11. On average, how often do you work with the family, landlord, employer, or other informal support network members for each consumer?
12. How many consumers have co-occurring disorders? How many receive individual or group SUD counseling?
14. How do you address consumers who are not willing/ready to be abstinent? Do you use hard reduction techniques? Please provide examples. Are you familiar with stage-wise approaches? How does your program use this approach?
15. How are consumers involved as members of the team? Are they paid? Full-time? Are they full-fledged members of the team?
Consumer Discussion

1. Describe your participation with the ACT team.
   a. What has been the most helpful?
   b. What has been difficult?

2. How is ACT different than other programs you’ve participated in?

3. Who have you interacted with from the ACT team this week?
   a. What about last week?
   b. Do you see the same people over and over or do you see different people?

4. How many times did you see an ACT team member during the past week?

5. How often do you see the team psychiatrist?
   a. Do you use the team psychiatrist for medications?

6. How often do you see the nurse?

7. Where do you see people from the ACT team most?

8. How often do you go to the ACT office?

9. What happens if someone says they don’t want ACT services anymore?

10. How often does the ACT team contact your family? Your landlord? Other people in your life?

11. How are consumers involved as members of your team?

12. What is the greatest accomplishment you have achieved since participating in ACT?

13. What is the one improvement you would make to ACT?

14. Is there anything you wish were included in ACT services that isn’t?

15. Is there anything else you’d like to add?
Family Member Discussion

1. Describe your family member’s participation with the ACT team.
   a. What has been the most helpful?
   b. What has been difficult?

2. How is ACT different than other programs your family member has participated in?

3. Describe your interactions with the ACT team.
   a. How did you participate in your family member enrolling in the ACT team?
   b. What has been the most helpful?
   c. What has been difficult?

4. What happens if you notice that your family member is having a problem or you are concerned about something with their care?

5. What happens when your family member says they don’t want ACT services anymore?

6. From your perspective, what is the greatest accomplishment your family member has achieved since participating in ACT?

7. From your perspective, what is the one improvement you would make to ACT?

8. Is there anything you wish were included in ACT services that isn’t?

9. Is there anything else you’d like to add?
## Appendix V. Outcome Evaluation Forms and Assessments

### AOT Care Team: Encounter/Outreach Log

<table>
<thead>
<tr>
<th>Svc Date</th>
<th>Consumer ID</th>
<th>Svc Recipient</th>
<th>Provider Name</th>
<th>Position</th>
<th>Type</th>
<th>Duration</th>
<th>Location</th>
<th>Objective</th>
<th>Provisions</th>
<th>Outcome</th>
<th>Notes</th>
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April 12, 2016 | 68
BEHAVIORAL HEALTH ASSESSMENT

Initial Information

Assessment Date:

Source of Information (select all that apply)

- □ ADS Recovery Provider  □ Client
- □ Case Manager  □ Conservator
- □ Family  □ Foster Parent
- □ MD  □ Other
- □ Parent/Legal Guardian  □ Previous Assessment
- □ Probation/Parole Officer  □ Social Worker
- □ Teacher/School  □ Therapist

If other, specify:

Reports reviewed:

Referral Source:

Presenting Problems/Needs:

What is working? What has been successful? What is positive? (Client’s reported strengths):

What has motivated the client to seek services now?

What would the client and/or caregiver like to achieve from services?

Potential for Harm/Risk Assessment

Current suicidal ideation?  □ No  □ Yes  □ Unknown/denied

Specify Plan (vague, passive, imminent, and level of lethality):

Access to means  □ No  □ Yes  □ Unknown/denied

Describe:

Previous attempts/ideations  □ No  □ Yes  □ Unknown/denied
Contra Costa County Behavioral Health Services
Assisted Outpatient Treatment Program – Evaluation Plan

Describe:

Current homicidal ideation?  ☐ No  ☐ Yes  ☐ Unknown/denied

Specify plan (vague, intent, with/without means):

Identified victim(s)  ☐ No  ☐ Yes

Victim(s) name and contact information:

Tarasoff warning  ☐ No  ☐ Yes

Reported to:

Date:

Past homicidal ideation?  ☐ No  ☐ Yes  ☐ Unknown/denied

Describe:

Has the client ever been a victim/perpetrator/observer of domestic violence?

☐ No  ☐ Yes  ☐ Unknown/denied

If yes, describe:

Domestic violence/safety/intervention plan:

History of abuse/trauma (past or present)

☐ No  ☐ Yes  ☐ Unknown/denied

If yes, describe:

Child Protective Services notification indicated:

☐ No  ☐ Yes

Client stressors

Someone significant has died  ☐ No  ☐ Yes  ☐ Unknown/denied

Recent move  ☐ No  ☐ Yes  ☐ Unknown/denied

Recent job change/lost job/retired  ☐ No  ☐ Yes  ☐ Unknown/denied
### Contra Costa County Behavioral Health Services
#### Assisted Outpatient Treatment Program – Evaluation Plan

<table>
<thead>
<tr>
<th>Stressor</th>
<th>No</th>
<th>Yes</th>
<th>Unknown/denied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Someone significant is ill and/or depends on client for care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client had or has health concerns</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>A close relationship has ended</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recently married</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>In debt</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Relationship concerns</td>
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<tr>
<td>Sexual concerns</td>
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<td></td>
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<tr>
<td>Financial concerns</td>
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<tr>
<td>Concerns meeting obligations and demands</td>
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<tr>
<td>Ongoing pressure at work/school</td>
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<tr>
<td>Recent change in family composition</td>
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<tr>
<td>Describe stressors: Crisis/Safety/Intervention Plan reviewed with client/guardian and emergency/after hour phone number was offered</td>
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</tbody>
</table>

**School History**

Is client currently attending school?
Contra Costa County Behavioral Health Services  
Assisted Outpatient Treatment Program – Evaluation Plan

Current school placement:

☐ Preschool  ☐ Elementary school  ☐ Middle school
☐ High school  ☐ Undergraduate  ☐ Graduate
☐ Vocational  ☐ Other

Name of school/program:

Area(s) of concern

☐ Academic  ☐ Behavioral  ☐ Social
☐ No school issue  ☐ Other

Describe are(s) of concern:

Client is or has been in a special education class

☐ Past  ☐ Present  ☐ N/A

Client has an active IEP

☐ No  ☐ Yes

Additional comment regarding school history:

Employment/Vocational History

Client is currently

☐ Employed  ☐ Seeking employment  ☐ Not currently in the job force
☐ Never been employed
☐ Limited legal employment history

Employment status

☐ Comp job 35+ hrs per week
☐ Comp job 20-24 hrs per week
☐ Comp job 20 hrs per week
☐ Rehab 35+ hrs per week
☐ Rehab 20-34 hrs per week
Contra Costa County Behavioral Health Services
Assisted Outpatient Treatment Program – Evaluation Plan

☐ Rehab 20 hrs per week
☐ Full time job training
☐ Part time job training
☐ Full time student
☐ Part time student
☐ Volunteer
☐ Homemaker
☐ Retired
☐ Unemployed/seeking work
☐ Unemployed/not seeking work
☐ Not in the labor force
☐ Resident/inmate
☐ Unknown

Most recent occupation:

Date last worked:

Income: ☐ Hourly ☐ Annually

Employer:

Primary source of income (past 30 days):

Employment history:

History of volunteer/community service work:

Vocational/school/job training:

Legal Information

Has the client been involved in the Criminal Justice System?

☐ Yes ☐ No ☐ Unknown/declined

Are you performing community service?
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unknown/declined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have outstanding tickets or traffic violations?</td>
<td></td>
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<tr>
<td>Are you required to pay child support?</td>
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<td>Are you required to pay spousal support?</td>
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<tr>
<td>Do you have revenue and recovery payments?</td>
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<tr>
<td>Do you require legal assistance?</td>
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<tr>
<td>Are you currently on probation?</td>
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<tr>
<td>Are you currently on parole?</td>
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<tr>
<td>Are you serving an alternative sentence?</td>
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</tbody>
</table>

Describe yes answers:

**Legal History**

Offense:

- □ Misdemeanor
- □ Felony

Date of arrest/conviction:

Time served:

Legal outcome:
Contra Costa County Behavioral Health Services  
Assisted Outpatient Treatment Program – Evaluation Plan

☐ Probation  ☐ Parole  ☐ Other

If other, specify:

(Duplicate format for each offense in the multi-iteration table)

Family History

Client’s living situation (print item selected from dictionary)

If client is living and/or residing in a home or apartment, please list those family members or significant others residing with them:

Have any relative and/or significant relationships experienced any of the following conditions (indicate who and expand below when applicable):

Substance abuse or addiction

☐ Yes  ☐ No  ☐ Unknown/declined

Indicate who (relationship biological, non-biological) and describe:

Other addictions

☐ Yes  ☐ No  ☐ Unknown/declined

Indicate who (relationship biological, non-biological) and describe:

Suicidal thought, attempts

☐ Yes  ☐ No  ☐ Unknown/declined

Indicate who (relationship biological, non-biological) and describe:

Emotional/mental health issues

☐ Yes  ☐ No  ☐ Unknown/declined

Indicate who (relationship biological, non-biological) and describe:

Developmental disabilities/delays

☐ Yes  ☐ No  ☐ Unknown/declined

Indicate who (relationship biological, non-biological) and describe:
Contra Costa County Behavioral Health Services
Assisted Outpatient Treatment Program – Evaluation Plan

Arrests
☐ Yes ☐ No ☐ Unknown/declined

Indicate who (relationship biological, non-biological) and describe:

Does client want involvement of family and/or others in treatment?
☐ Yes ☐ No ☐ Not at this time

Additional comments:

Social History

Peer/social support
☐ Yes ☐ No ☐ Unknown/declined

Community support
☐ Yes ☐ No ☐ Unknown/declined

Self help/12 Step support
☐ Yes ☐ No ☐ Unknown/declined

Substance use by peers
☐ Yes ☐ No ☐ Unknown/declined

Gang affiliation
☐ Yes ☐ No ☐ Unknown/declined

Sexually active
☐ Yes ☐ No ☐ Unknown/declined

Experience stigma, prejudice, bullying, or problems with peer relationships
☐ Yes ☐ No ☐ Unknown/declined

Close friendships
☐ Yes ☐ No ☐ Unknown/declined

Additional information (if applicable):

Developmental/Medical History
Contra Costa County Behavioral Health Services
Assisted Outpatient Treatment Program – Evaluation Plan

Allergies were reviewed with client (any reported allergies MUST be entered into OrderConnect)

☐ No known allergies ☐ Yes

History of head trauma, toxins, loss of consciousness, seizures, high fevers impacting neurological functioning

☐ No ☐ Yes

Describe:

Hospitalization (mental or physical health)

☐ No ☐ Yes

If yes, describe:

Does client have a Primary Care Physician?

☐ Yes ☐ No

Was client provided a referral to a Primary Care Physician?

☐ Yes ☐ No

Client’s Primary Care Physician:

Phone number:

Current health condition(s) impacting client functioning

☐ Yes ☐ No

If yes, describe:

Is the condition followed by Primary Care Physician?

☐ Yes ☐ No

Currently pregnant?

☐ Yes ☐ No ☐ Unknown, N/A

Check all that apply

☐ Sleep disturbance
☐ Obesity/overweight/underweight
☐ Appetite or eating disturbance

Date of last physical, if known:
Date of last dental exam, if known:

Date of last hearing exam, if known:

Date of last vision exam, if known:

Annual physical health evaluation by Primary Care Physician recommended

☐ No (recent physical reported)
☐ Yes
☐ N/A

Psychiatric evaluation

☐ No referral made at this time
☐ Currently treated by:
☐ Referral to :

Does client indicate any developmental challenges/concerns?

☐ Yes ☐ No

Significant developmental information (when applicable):

Mental Status Exam

Appearance

☐ Older than stated ☐ Younger than stated ☐ Eccentric
☐ Meticulous ☐ Dress and grooming appropriate ☐ Seductive
☐ Unique features ☐ Poor hygiene

Describe:

Eye contact

☐ Good ☐ Fair ☐ Poor

Describe:

Speech
Contra Costa County Behavioral Health Services  
Assisted Outpatient Treatment Program – Evaluation Plan

<table>
<thead>
<tr>
<th></th>
<th>Normal for age/situation</th>
<th>Overly talkative</th>
<th>Rapid</th>
<th>Monotone</th>
<th>Stammer/stutter</th>
<th>Other difficulty</th>
<th>Soft</th>
<th>Brief responses</th>
<th>Pressured</th>
<th>Excessive profanity</th>
<th>Vocal tic</th>
<th>Loud</th>
<th>Non-verbal</th>
<th>Rambling</th>
<th>Slurred</th>
</tr>
</thead>
</table>

Describe:

**Attitude**

- Responsive
- Uncooperative
- Guarded/distant
- Manipulative/dishonest
- Dramatic

Describe:

**Behavior/Motor activity**

- Normal for age/situation
- Overactive, restless
- Unusual mannerisms
- Other involuntary movement

Describe:

**Mood**

- Happy
- Irritable or angry
- Fearful

Describe:

**Affect**

- Euthymic (normal)
- Euphoric
- Anxious
- Labile (rapidly shifting)
- Incongruent with topic or thoughts

Describe:
Contra Costa County Behavioral Health Services
Assisted Outpatient Treatment Program – Evaluation Plan

Perceptions

☐ Normal ☐ Auditory hallucinations
☐ Visual hallucinations ☐ Other hallucinations
☐ Other perceptual distortion

Describe:

Thought Process

☐ Linear and rational ☐ Flight of ideas
☐ Disorganized or loose ☐ Perseverating
☐ Loose Association

Describe:

Thought Content

☐ Normal ☐ Delusions ☐ Obsessions
☐ Excessive preoccupation ☐ Unusual, non-delusional ideations

Describe:

Thoughts of harming self or others

☐ None ☐ Suicidal ideation
☐ Suicidal intent ☐ Thoughts or intent of non-lethal self-harm
☐ Thoughts or intent of harming another person

Describe:

Sensorium

Oriented to

☐ Person ☐ Place ☐ Time ☐ Situation

Memory intact for

☐ Immediate ☐ Recent ☐ Remote

Alertness

☐ Alert ☐ Clouded/confused ☐ Other

Attention

☐ Good ☐ Fair ☐ Poor

Intellectual functioning
Contra Costa County Behavioral Health Services
Assisted Outpatient Treatment Program – Evaluation Plan

☐ Average or higher  ☐ Below average

Insight/judgment
☐ Good       ☐ Fair        ☐ Poor

Describe:

Substance Use Information

History of substance use
☐ Yes       ☐ No        ☐ Client declined to report

Name of Drug:

Drug of choice rating:

Method of administration
☐ Inhalation    ☐ Injection (IV or intramuscular)
☐ None or not applicable  ☐ Oral
☐ Other        ☐ Smoking

Age first used:

Date regular use began:

When did you first realize that you had a problem?

Frequency of use:
☐ Never                   ☐ One to three times a year
☐ One to three times a month ☐ One to three time a week
☐ More than three time a week

Days of use in the last 30 days:

Date of last use:

Amount of last use:

(repeat for each item on listed on multi-iteration table)
History of withdrawal symptoms (sick, shaky, depressed, etc.)

☐ Yes  ☐ No  ☐ N/A

Have you ever experienced blackouts?

☐ Yes  ☐ No  ☐ N/A

Have you ever experienced seizures?

☐ Yes  ☐ No  ☐ N/A

Have you ever experienced alcohol poisoning?

☐ Yes  ☐ No  ☐ N/A

Have you ever overdosed?

☐ Yes  ☐ No  ☐ N/A

Have you ever been hospitalized because of substance use?

☐ Yes  ☐ No  ☐ N/A

Have you ever tried to cut down or stop?

☐ Yes  ☐ No  ☐ N/A

Problems with family or friends because of substance use?

☐ Yes  ☐ No  ☐ N/A

Legal problems related to substance use

☐ Yes  ☐ No  ☐ N/A

Describe all yes answers:

Recommendation for further substance use treatment?

☐ Not applicable  ☐ No  ☐ Yes

Describe:

Culture/Diversity

Assess the unique aspects of the client, including culture and background that are important for understanding and engaging the client and for care planning.
Family’s country of origin (parent 1) (print selection from dictionary):

Family’s country of origin (parent 2) (print selection from dictionary):

Year moved to the USA (when applicable) – client:

Year moved to the USA (when applicable) – parent 1:

Year moved to the USA (when applicable) – parent 2:

Culture client most identifies with:

Importance of identified culture of client

☐ Very important  ☐ Somewhat important

☐ Important  ☐ Not important

Culture-related healing practices used:

Acculturation information:

Clinical Conclusion

Stage of Change

☐ Precontemplation  ☐ Contemplation

☐ Preparation  ☐ Action

☐ Maintenance

Clinical conclusion:

Medical Necessity met?  ☐ Yes  ☐ No

When No, note date NOA-A issued (Medi-Cal clients only)
If client has questions regarding the intake process and/or forms, have questions been answered? □ Yes □ N/A

Signature: Date:
Appendix VI. Qualified Request Protocol

Qualified Requestor Protocol

1. Please describe the circumstances that have lead you to request that an individual with severe mental illness receive AOT services.
   a. Describe any types of specific behaviors or history of behaviors that would lead you to file a request for petition for AOT services.
   b. Under what circumstances would you elect not to request that an individual with severe mental illness receive services?

2. What if any supporting documentation do you rely on to help you make a determination of whether or not to request AOT services for an individual?

3. How would you describe the request for petition process for AOT services?
   a. What is working well as it relates to this process?
   b. What challenges exist?

4. What are your impressions of the investigation process that follows the request of petition for AOT services?
   a. Do investigations proceed in a timely manner?
   b. In your opinion, are individuals assessed fairly?

5. For individuals that you have requested receive AOT services, what has happened to them as a result?
   a. Do you know if they have received services as a result of your request (mental health treatment, shelter, family counseling etc.)?
   b. [If YES] How quickly did they begin to receive services as a result of AOT?
   c. [If NO] What set of factors interfered?

6. Describe your level of comfort acting as a requestor of AOT services for an individual.
   a. What makes you comfortable or uncomfortable with the AOT process?

7. Is there anything you wish were implemented to improve the request for petition process of AOT services for individuals with severe mental illness?

8. Is there anything else you’d like to add?
Appendix VII. Human Subjects Considerations

Human subject’s considerations are an important component of the ACT program given the highly sensitive participant-level health information that will be obtained and exchanged during the program. Contra Costa County does not foresee any physical, medical, psychological, social, and legal risks or potential adverse effects because of participation in this program. The ACT program is designed to minimize the risks associated with serious mental illness, untreated or undertreated medical conditions, and co-occurring substance use while providing supports to address the impact of health disparities and social determinants of health. Consumers receiving integrated health services should benefit through improved health outcomes and access to primary care.

Contra Costa County (CCBHS) plans to closely monitor service delivery and the channels of communication to ensure that there are no adverse effects to consumers if gaps in communication arise. A tracking mechanism using EHR will be set-up for referrals, follow-up communications from consultations, and hospital data to ensure that new modes of communication do not result in unmet health needs.

New ways of collaborating across service delivery partners can prompt issues related to confidentiality. Contra Costa County currently collaborates with a number of social, behavioral health, and healthcare agencies and has HIPAA-compliant release of information (ROI) forms. However, new service partners may decide to only share protected health information (PHI) when signed ROIs are in place. As such, CCBHS and their ACT service provider, Mental Health Systems (MHS), plans to include a set of ROIs in the standard intake to ensure that ROIs are in place before a situation arises that requires the ability to share PHI.

The ACT program is designed to provide regular and frequent contact with the individuals receiving services. As such, all participants will be seen and assessed for medical and behavioral health conditions and any adverse effects from participating in the program. If a participant demonstrates any adverse effects or has an increase in medical or behavioral health symptoms, the ACT team will immediately review and revise the treatment plan to adjust the supports being received to address the arising issues.

CCBHS and MHS will utilize means of treatment which improve health outcomes for consumers in the most efficient and effective manners possible. The ACT program is rooted in individual- and systems-level evidence-based practices. CCBHS and MHS strive to provide the least restrictive and intrusive interventions available and will also follow the ACT model as outlined in the evidence.

Fair Selection of Participants

The ACT program is designed to serve people with serious mental illness who have or are at-risk for developing co-occurring primary care conditions and chronic diseases. The target population is traditionally underserved, and is likely to be experiencing substance abuse problems, homelessness or unstable housing, be extremely poor or without income, involved with the criminal justice system, and/or has disruptions in social and family relationships. Members of this target population have a high
level of need with chronic and untreated co-occurring conditions, are less likely to seek traditional services, and more likely to experience significant consequences without care. Despite a high level of need for services, most receive urgent and emergency care only for their mental health and medical needs in jail, hospital, and emergency room settings.

This program is targeted for people with severe mental illness who have untreated medical conditions and historically have not engaged in mental health treatment. CCBHS’s experience suggests that these individuals are also vulnerable to involvement with the criminal justice system, homelessness, extreme poverty, and other social determinants of health. The ACT program allows the opportunity for consumers to engage voluntarily at numerous junctures in the program. However, if referred consumers refuse treatment they may receive court orders that mandate engagement with treatment. However, the court does understand that enforcement mechanisms may not always be enforceable.

Until the volume of referrals exceeds available ACT program slots, CCBHS plans to select all participants who meet the criteria for ACT participation. If the volume of demand exceeds treatment availability, CCBHS will triage participants, similar to an urgent or emergency care setting prioritizing those who have the highest risk of hospitalization, institutionalization, or incarceration because of untreated medical and behavioral health issues. CCBHS screens all referrals using the ACT screening assessment as identified in the evidence-base to determine if consumers meet the requirements for enrollment into ACT.

Absence of Coercion

Participation in this project is voluntary, as are all ACT services. CCBHS does work with Contra Costa’s specialty courts (i.e. mental health court, drug court, homeless court) to be a resource for people who are eligible to receive services as an alternative to jail. Consumers participating in ACT through AOT court orders still do so voluntarily and cannot be obligated to receive services.

CCBHS does not offer compensation or incentives to any participants currently, but does recognize the power they currently possess in facilitating access to services through AOT court orders. Given the sensitive nature and the use of enforcement mechanisms (i.e. AOT court orders) CCBHS throughout the entire process will always offer consumers the opportunity to participate voluntarily. Furthermore, even with an AOT court order consumers must consent to receive services. The process of informed consent begins at intake when the consent forms are initially presented. CCBHS believes that informed consent is more than signing a form and try to engage all consumers in a discussion about options, risks, benefits, and choices to ensure that they are making an informed decision. Given that the data collection occurs at intake, quarterly, semi-annually, and at discharge, CCBHS plans to reinforce the separation of informed consent for services versus evaluation when we schedule each interview. Persons will be given the opportunity to consent for service provision and evaluation activities separately, and decisions to not consent to evaluation activities does not preclude receipt of services through AOT.

Privacy and Confidentiality
CCBHS ensures that measures are in place to protect privacy and confidentiality by training every staff member in HIPPA and 42 CFR standards and holding them accountable for compliance. Given the collaborative nature of the ACT program, CCBHS has planned to implement a process to allow for Releases of Information (ROI) remain in place for all of the necessary partners including hospitals, healthcare facilities, specialist care providers, social service providers, and family or other support individuals.

CCBHS believes that not only are health related issues confidential, but insurance and billing discussions should be private as well, and CCBHS will make sure that there is a private space to discuss these matters.

CCBHS also regularly uses items such as the following to ensure patient confidentiality and privacy:

- Refraining from discussing sensitive issues when the patient is standing at the reception window and within earshot of those in the waiting room
- Using first names only when calling patients from the waiting room
- When providing patients with drug samples, also provide a bag for them to discreetly carry the medication through the waiting room
- All patients are assigned a Unique Patient Identifier and this will be used on all consumer records
- Leaving non-detailed messages on voicemails and answering machines
- All consumer data will be securely stored in an electronic system with tiered access depending on the level of patient contact. All data will be password protected and will require regular password changes

Individual data collected as part of the treatment process that is used to inform service planning and delivery will be stored in the participant’s chart and EHR. CCBHS has a space for participant charts that is double-locked (cabinet and door). All treatment team members will have access to the charts, but further access will be restricted for other staff members.

Only staff members collecting and entering data and the evaluators will have access to the data. In addition, any data sent to the evaluator will be password protected and/or encrypted. Furthermore, the data sent to the evaluators will be stored on a secure server at the evaluator’s site and data will only be accessed through the secured server and at office computers, which are all password-protected. The secure server is also under 24-hour camera monitoring. No data with personal identifiers will be taken home by either CCBHS or MHS staff or the evaluation team.

**Participant Consent Procedures**

CCBHS currently uses a consent form for services. For the evaluation, CCBHS will also incorporate an evaluation consent form. The evaluation consent form will inform people of the purpose of the evaluation, risks and benefits, and contact information should they have questions or concerns. The consent form will also inform CCBHS consumers of the voluntary nature of the evaluation and let them
know that they can stop participating in the evaluation at any time and their participation will not impact their ability to receive services. All consent forms will include:

- That participation in the program and evaluation is voluntary and that a person can continue to receive services if they elect to not participate in the evaluation.
- That the person can withdraw from services and/or the evaluation at any time.
- The risks and benefits of participation in the program and evaluation.
- How we plan to protect them from the stated risks and how we will respond if someone experiences an adverse effect from participating.
- Contact information of relevant staff members and the evaluators if questions do arise.

Please refer to Appendix VII: Evaluation Consent Form for the CCBHS ACT program’s participant evaluation consent form.

CCBHS regularly provides services to people who have limited literacy and whose preferred language is not English. All of CCBHS’s materials are designed to be accessible at the fifth grade reading level, and no consumer is given forms to read and sign without staff explanation. All consent procedures and forms requiring signature are presented by a team member who offers explanation and discussion about the information. Using this approach, it can be ensured that people develop an understanding of the material and are able to make an informed choice without having to admit lower levels of literacy or difficulty understanding. CCBHS also uses a on-site and video translation services for those who prefer services in another language. When a family member is available for translation, CCBHS ensures that the person is informed of the availability of the translation service so that they can make an informed choice as to how they wish to communicate with CCBHS staff.

All consumer participating in the ACT evaluation will be given information materials about CCBHS, the ACT program, and the program’s evaluation. Additionally, consumers will be given a copy of any and all forms that they sign, their initial person centered plan and any updates, required HIPAA information, and a copy of their consumer and patient rights. CCBHS will also provide contact information for how to get in touch with the ACT team, how to file a grievance, and what to do in an emergency.

As CCBHS does not intend to target the elderly or minor children, the evaluation has not developed specific consent procedures for those populations.

Risks and Benefits of Participation

The risks of participating in the ACT program are minimal. There is always potential that participant information could be inadvertently disclosed outside of appropriate staff (e.g. computer hacks). However, CCBHS and MHS have computers and electronic health records that are password-protected and encrypted. Furthermore, all electronic data will only be stored on CCBHS and MHS computers at the office and no data will be taken home by staff members.
During transmission of data to the evaluation team, data could be intercepted. Any files sent to the evaluation team will be encrypted and password-protected, and the password will be held in a separate file and be agreed upon previous to the start of data transmission. Furthermore, the data sent to the evaluation team will be stored on a secure server at the evaluation team’s site and data will only be accessed through the secured server and at office computers, which are all password-protected.

The expected benefits of improved health outcomes greatly outweigh the risks associated with participation. Benefits include a more tailored and personalized approach to health care for this particularly vulnerable population. Participants will receive integrated services that would not normally be available to them outside of the ACT program and should benefit from this integrated approach.
Appendix VII: Evaluation Consent Form

Contra Costa County Behavioral Health Services: AOT Evaluation

Voluntary Consent to Participate in Evaluation Research

We invite you to participate in an evaluation of Contra Costa County Behavioral Health Services’ Assisted Outpatient Treatment (AOT) program. The program is funded through the State of California Department of Healthcare Services (DHCS). DHCS funds programs designed to reduce the impact of substance abuse and mental illness. CCBHS has hired Resource Development Associates (RDA), a consulting firm, to conduct a comprehensive evaluation of the AOT program.

Taking part in this evaluation is completely voluntary. If you have any questions about this evaluation, you should discuss it with CCBHS and Mental Health Systems staff.

What is the purpose of the evaluation?

You are being offered the opportunity to take part in the evaluation because you are receiving services through the AOT program. This evaluation is being done to see if the program is making a difference and how the program can be improved. Participation for this evaluation is being offered to everyone who receives services through the AOT program, which will be approximately 75 people.

What are the evaluation procedures?

As part of the AOT program evaluation, we will use information and data collected by CCBHS and Mental Health Systems as part of the services you receive through AOT. We may also request information from the County regarding involvement in the criminal justice system. This may include information such as personal identifiers (e.g., name, date of birth, etc.). In order for the evaluation to be able to link your records over the course of the program, it is important to have personal identifying information. Your personal identifying information will not be used for any other purpose. Additionally, we will also receive health information and information regarding your behavioral health and substance use. All of this information will be collected as part of the regular visits during your participation in the AOT program.

As part of the evaluation, there may be times when you will meet and speak with the evaluation team. This may be during on-site team visits and during focus groups. You will only be asked to participate in one focus group. The visits and focus groups will be used to gather additional feedback that you may have regarding the services you are receiving.

You will receive the same services and same procedures as all other persons who are participants of the AOT program in Contra Costa County, even if you decide not to participate in this evaluation.

How long will participation take?
Any additional time that you will spend participating in this evaluation will be during on-site team visits and focus groups. These visits and focus groups are expected to last approximately 60 minutes. We will collect your information over the entire evaluation period of four years.

**What are the discomforts and risks?**

The discomforts and risks of the evaluation are minimal. There may be times during the focus groups and visits that you will be asked sensitive questions that may make you feel uncomfortable; you do not have to answer if you do not want to. There is also potential loss of confidentiality, but this is very low chance.

All your personal records will be stored in locked cabinets. Any information that is stored electronically will be kept on password protected computers. Your information will only be kept on secure servers and on work computers; none of your personal information will be taken home.

The final public evaluation will **NOT** disclose any personal information. Your name, address, or any other identifying information will **NOT** be published. Also, we must notify the relevant authorities if any of the following arises: (1) You are planning to hurt yourself or others; (2) Someone is causing you physical pain, harm, or suffering; and/or (3) Someone is hurting a child.

**Who should I contact with questions?**

If you have any questions regarding this evaluation, you should contact Warren Hayes at Warren.Hayes@hsd.cccounty.us or (925)-957-5154. You may also contact the lead researcher of the evaluation, Roberta Chambers, at rchambers@resourcedevelopment.net or (510)-488-4345.

**Signature and Consent to Participate**

Signing this form is completely voluntary. If you do not sign it, we will not use your information and you can still get services. You can always change your mind and ask that your information no longer be shared or that it be erased.

To change your consent, please call or email Roberta Chambers at rchambers@resourcedevelopment.net or (510)-488-4345 or Kevin Wu at kwu@resourcedevelopment.net or (510)-488-4345.

Signing this form is completely voluntary. I have read this form and I agree to everything written here.

______________________________                             __________________________________________
Print Name of Participant           Signature of Participant                        Date

_______________________________                           __________________________________________
Person Obtaining Consent                                               Signature of Person Obtaining Consent        Date