

COUNTY OF LOS ANGELES

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DEPARTMENT OF MENTAL HEALTH

<http://dmh.lacounty.info>

550 SOUTH VERMONT AVENUE, LOS ANGELES, CALIFORNIA 90020

Reply To: (213) 738-4601  
Fax: (213) 386-1297

February 24, 2011

Cliff Allenby, Acting Director  
California Department of Mental Health  
1600 9<sup>th</sup> Street  
Sacramento, CA 95814


Dear Dr. Allenby:

This is to submit an outcomes report for the Los Angeles County Department of Mental Health (DMH) Assisted Outpatient Treatment (AOT) Program as required by the State Department of Mental Health. Please find the report attached.

Although our AOT Program is small, we are pleased that we have been successful in assisting several individuals to stabilize and reintegrate into the community with significant reductions in incarceration and hospitalization. We intend to continue the program and refine our ability to identify and collect outcome data so that we will be able to provide reports in accordance with State requirements.

Please contact me with any questions at (213) 738-4601.

Sincerely,

  
Marvin J. Southard, D.S.W.  
Director of Mental Health

MJS:TB:MM:mm

Attachments

c: Robin Kay, Ph.D.  
Tony Beliz, Ph.D.  
Mary Marx, L.C.S.W.

## COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

### ASSISTED OUTPATIENT TREATMENT PROGRAM OUTCOMES REPORT

April 1, 2010 – December 31, 2010

#### OVERVIEW

In April 2010 the Los Angeles County Department of Mental Health (DMH) implemented a voluntary pilot Assisted Outpatient Treatment (AOT) program administered by Countywide Resource Management (CRM) for individuals with mental illness involved in the criminal justice system, in the psychiatric units of County hospitals or in Institutions for Mental Diseases (IMDs). DMH is utilizing existing Mental Health Services Act (MHSA) funding to contract with Gateways Hospital and Mental Health Center (Gateways) to provide a voluntary AOT program that is available to Los Angeles County residents. The Gateways' AOT program serves ten individuals at any given time, with an anticipated length of stay of six months. The program provides a staff-to-client ratio of one to ten. Gateways provides wrap-around services and housing at Percy and Normandie Village Adult Residential Facilities for participants in the program. Emergency or crisis intervention services are available 24 hours per day, 7 days per week. Housing AOT participants in a residential setting with intensive supportive services promotes ongoing engagement and participation in the AOT program.

In addition to Assembly Bill (AB 1421) criteria, eligibility criteria for the AOT program include:

- Misdemeanor incompetent to stand trial defendants (Penal Code 1370.01) who have been adjudicated restored to competency by the Los Angeles County Mental Health Court and are exiting the legal system;
- Misdemeanor defendants at risk for becoming incompetent to stand trial;
- Individuals transitioning from alternative sentencing programs; and
- Individuals transitioning from County hospitals and IMDs who would be able to live safely in the community if they participated in the recommended AOT program.

#### OUTCOMES REPORT

This is a report on persons served and clinical outcomes of the AOT program from April 2010 to December 2010, as required by State Department of Mental Health (SDMH). The report contains the results of the effectiveness of the strategies employed by the program in reducing homelessness, hospitalizations and involvement with local law enforcement of persons in the program. The report lists each question or issue raised by SDMH, with the responses beneath.

- (1) *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.*

Since the inception of the AOT program in Los Angeles County, ten persons have been served. As of this report, two were successfully discharged to lower levels of care, two went Absent Without Official Leave (AWOL), two were hospitalized, one was arrested, and three remain in the program.

|  |    |
|--|----|
| # successfully discharged to lower levels of care: | 2  |
| # AWOL   | 2  |
| # hospitalized:                                    | 2  |
| # arrested:  | 1  |
| # still in the program:                            | 3  |
| Total # of individuals served:                     | 10 |

- (2) *The number of persons in the program with contacts with local law enforcement, and the extent to which local and state incarcerations of persons in the program has been reduced or avoided.*

- During the six months prior to enrollment in AOT, program participants were incarcerated for approximately 388 days.
- During the six months since enrollment in AOT (six months have not lapsed for all participants), program participants were incarcerated for approximately 85 days or a reduction of 78%.

- (3) *The number of persons in the program participating in employment services programs, including competitive employment.*

No program participants have engaged in employment services or competitive employment, although access to these services is available.

- (4) *The days of hospitalization of persons in the program that have been reduced or avoided.*

- Six months prior to enrollment in AOT, program participants had approximately 345 days of hospitalization.
- While enrolled in AOT one participant was hospitalized for psychiatric reasons for a total of 49 days or a reduction of 86%.
- Since discharging from AOT, program participants have had approximately 81 days of hospitalization or a reduction of 77%.

(5) *Adherence to prescribed treatment by persons in the program.*

- 80% of the individuals served were compliant with treatment during their participation in the program.
- 20% were non-compliant with treatment during their participation in the program.

(6) *Other indicators of successful engagement, if any, by persons in the program.*

Examples of successful engagement by persons in the AOT program are described below.

S.L. was admitted to the AOT program on 11/19/10. Mr. L.'s support network consists of his mother, girlfriend, children, and cousin. They consistently visit him at the program on a weekly basis. In addition, Mr. L. has started to participate in day passes with family members (including his girlfriend) on the weekends, outside of the facility. He has been able to consistently return to the program by the specified times and returned without contraband, and not under the influence of alcohol/illicit drugs. Mr. L.'s support network provides emotional support, in addition to bringing him food, clothing, and hygiene/grooming supplies.

Mr. L. initially struggled with getting along with peers and staff. He was involved in verbal altercations/posturing with female peers and displayed manipulative behavior towards staff. However, he is currently compliant with staff and demonstrates pro-social behavior towards peers.

Mr. L. consistently accesses community resources on a weekly basis. He purchases needed items at the local store and frequents the neighboring restaurants. During these outings into the community, he is able to demonstrate good money management skills as he checks out money, brings back receipts for transactions, and accurate change.

J.P. was admitted to the AOT program on 8/19/10 from a county hospital. Mr. P.'s family resides out-of-state, Nebraska and Utah. Mr. P. has contact with his family through letters and cards weekly as well as daily phone contact. Mr. P. met his girlfriend at Percy, and she has recently moved to a Board and Care in which client has frequent phone contact with her and has been out on day passes to visit her.

Mr. P. is making acquaintances and now has a girlfriend and best friend. He is able to also separate his own treatment from his friends and remove himself from peer pressure to ensure his sobriety. Mr. P. has increased his attendance and actively participates in groups as well as individual sessions with therapist.

Mr. P. obtained a bus pass, which he is responsible to request money and obtain his renewal on his own. Mr. P. attends an outside drug treatment program a few times a week, plus a couple AA and NA meetings when needing extra support. Mr. P. purchased a map of the city and enjoys exploring new churches and navigating to places he goes on his own. Mr. P started the GED process by being assessed this week and desires to enter the workforce in the future or volunteer his services to people struggling with dual diagnosis like him. Mr. P just graduated from the AOT program on 2/18/11 but wishes to stay in IMD step-down program for supportive services to aide in his medical, therapeutic, and GED completion.

P.S.L. was admitted to the program on 10/8/10 from a county hospital. Since admission, Ms. L. has shown progress in the areas of improved family relationships, increased socialization skills with peers/staff, and increased access to community resources.

Ms. L.'s support network consists of her mother. Her family resides over an hour away. Ms. L. was homeless before coming into AOT program and had lost contact with her family for years so her frequent phone contact with her mother was an improvement. She spoke of desiring a better relationship with her family but that her behavior had impaired those relationships. Ms. L.'s depression caused her to withdraw to her room. She has been slowly making acquaintances and most recently a close friendship with her last roommate. Her group attendance and participation has increased over the last few months.

A.G. was admitted to Percy Village in the AOT program on 4/7/10. He spoke to members of his family on the phone on a daily basis. He looked to his family for support, and his mother was very involved in his life. This is something that greatly increased during his time at Percy Village. Prior to his admission and hospitalization, Mr. G. was homeless. This served as a barrier to his maintaining contact with his family. Upon securing housing at Percy Village, he was able to strengthen his family relationships, as well as develop new friendships.

Mr. G. became somewhat of a leader among his peers while at Percy Village. He advocated for himself and his peers, although not always in the most appropriate way. He was well liked by his peers, spent much time in the milieu, and developed some lasting friendships while at Percy. In addition he sought out community resources while in the program including applying for General Relief and worked on picking out a school to further his education on discharge from the program.

C.M. was admitted to the program on 4/9/10 from a county hospital. During her stay, her support network consists of her sister and her Full Service Partnership (FSP) worker, Kara. She was discharged from program on 12/9/10. During her stay she had consistent contact with her sister by way of phone and participated in family passes on weekends to her sister's apartment where she now resides. Ms. M. was

predominately isolative and anxious when she entered the program. She made two good friends while in treatment and socialized with others in the milieu as well as increased attendance and participation in groups. She was able to shop at a local store independently and requested assistance to go shopping when more substantial purchases needed to be made. Ms. M. actively participated in special weekend outings scheduled by activities coordinator and learned to manage her money and increased her activities in the community during her time in the program.

(7) *Victimization of persons in the program.*

There were no instances of victimization of program participants.

(8) *Violent behavior of persons in the program.*

There was one instance of violent behavior, resulting in the participant being placed on an involuntary hold and admitted to a psychiatric hospital.

(9) *Substance abuse by persons in the program.*

One program participant reported abusing substances while enrolled in the program.

(10) *Type, intensity, and frequency of treatment of persons in the program.*

Treatment was planned and delivered from individual service plans developed with program participants and the AOT Personal Services Coordinator that were specific to the needs of each participant. Treatment offered included individual, group, medication support, targeted case management, and benefit establishment/re-establishment. AOT participants receive both individual and group treatment on a daily basis. They are usually seen for at least 30 minutes a day individually, in addition to attending 4-6 groups per day. They receive case management services 1-2 times per week on average. All services, including medication support, are individualized according to each person's need.

(11) *Extent to which enforcement mechanisms are used by the program, when applicable.*

Enforcement mechanisms were not used in the AOT program.

(12) *Social functioning of persons in the program.*

The AOT program utilizes the Multnomah Community Ability Scale (MCAS) to measure the participant's level of functioning (Attachment I). The MCAS is a

## MULTNOMAH COMMUNITY ABILITY SCALE INSTRUCTIONS

### Instructions and Examples for each Item

Included here are instructions for rating each item. These instructions were compiled by the authors and include suggestions from two groups of clinicians who have used the scale extensively.

#### **Question 1 – Physical Health**

Some chronically mentally ill people misinterpret or don't experience symptoms or health problems, so it is important to verify the status of a client's health from other data on physical condition if at all possible. Use nursing staff as consultants as possible and needed. Many chronically mentally ill clients are scored 5 because their disability is psychiatric and not physical. Remember that a health condition is not the same as a health impairment. Some examples are that a controlled seizure condition would be scored 4, and a poorly controlled or uncontrolled seizure condition would be scored at less than 4, depending on the severity and lack of control.

#### **Question 2 – Intellectual Functioning**

Generally 5 indicates Intelligence Quotient (IQ) of 90 or above, 4 indicates the 80s, 3 indicates the 70s, 2 indicates the 60s, and 1 indicates below 60 according to an accepted test of intelligence such as the Winchester Adult Intelligence Scale. However, in the absence of tested intelligence, estimate the level of intellectual functioning from behavioral cues. Since the scale is intended to measure clinician's perception, rate the item in terms of your perception of the client's intellectual functioning (independent of psychotic symptomatology).

#### **Question 3 – Thought Process**

Consider the client's ability as he/she is when rated, whether that be on or off medications, independent of other services. If the client has changed within the time period rated, use the most recent condition.

## Multnomah Community Ability Scale Instructions

Page 2

### **Question 4 – Mood Abnormality**

Notice that mood may include range, level, appropriateness, and therefore is not unidimensional. Disability in any of these elements may cause a person to have a low score. Different psychopathologies may manifest in different elements of mood.

Both questions 3 and 4 are sometimes confusing since the clinician must ascertain behavioral presentations of mental disorder. Consider the diagnostic indications in the clinical record, and look for consistency in disparate write-ups. Any elements which reflect thought or mood (such as range, appropriateness, level) may be cause for a lower score. It may help to establish “benchmark” clients in your clinical practice.

### **Question 5 – Response to Stress and Anxiety**

The client’s response to work, living independently, changes in life status, family discord, interpersonal conflict, new social demands, etc. may reveal an impaired response to normal stressors. Impairment could be due to inappropriate responses to stressful events or difficulty in handling anxiety as evidenced by agitation, perseveration, inability to problem-solve, etc. A client may become hostile or aggressive, self-destructive, antisocial, or have other outward manifestations or poor coping. A client may also withdraw or actively isolate him/herself. Pay special attention to the quieter manifestations which may be less obvious or socially troublesome but are still dysfunctional for the client.

### **Question 6 – Ability to Manage Money**

If there is no indication that the client has any trouble managing money, assume that she/he manages it successfully. If the client only manages a slight amount of money because most of it is managed by someone else, rate below 3. If the client only manages a slight amount of the money she/he could have, rate lower; if she/he is managing a small amount because that is all she/he has left over after rent and food, rate somewhat higher. Rate what clients ARE doing, not what they MIGHT do if they had a chance. If a client is not managing money, she/he cannot be scored higher than a 1 or 2.

### **Question 7 – Independence in Daily Living**

If a client resides in a residential care facility or is hospitalized, the rating would generally be 3 or less. Clients who are hospitalized can be rated on this dimension in terms of how far and how fast they proceed through the hierarchy of hospital privilege. Street people present a different subgroup for rating. Their rating should reflect the degree of quality or success they accomplish in meeting their basic needs. For clients in a structured residential setting, most ratings are 3 or less.

**Multnomah Community Ability Scale Instructions**  
page 3

**Question 8 – Acceptance of Illness**

You may wish to ask the client about this issue prior to rating the item. Some insight into or verbal admission of the client's mental illness is necessary for a high rating. Remember that issues of medication compliance and compliance with treatment are rated in items 14 and 15 and should not be considered in this question. An attitude of non-acceptance of illness if considered denial to the extent that it interferes with treatment.

**Question 9 – Social Acceptability**

Consider this item within the range of the client group rather than general population. Consider physical appearance, behavior in public situations, and reports from others. If appearance and behavior motivate others to cross to the opposite side of the street, a low rating is required. Clients with bipolar disorders tend to be rated 3 because of their changeable or contrasting behaviors. Responses of the general public are relevant here, rather than a negative peer group who may encourage or enforce socially unacceptable behaviors.

**Question 10 – Social Interest**

On this question, do NOT consider the quality or acceptability of the contact. This item is a measure of the frequency of social interest without the judgment of the appropriateness which is the core in question 9 and 11.

**Question 11 – Social Effectiveness**

Behavior which is aggressive, intrusive, inappropriate, goal-inappropriate, illegal, immoral, or ridiculous causes this item to be rated low.

**Question 12 – Social Network**

One group's guidelines for ratings of social network were:

- 1 = nobody
- 2 = family member or a case manager
- 3 = family member and a case manager or a friend or a socialization group
- 4 = family member and a case manager and a friend or a socialization group
- 5 = perhaps all of the above and then some

**Question 13 – Meaningful Activity**

The difference between 1 and 2 is the difference between "nothing and something". Sociable clients may achieve a 4 or 5. For situations such as watching TV or sitting in a

**Multnomah Community Ability Scale Instructions**  
Page 4

bar, the guideline is whether the client is involved in the situation rather than sitting withdrawn and isolated.

**Question 14 – Medication Compliance**

If a hospitalized client has refused medication and an independent medical consultant has evaluated medication refusal, then rate 1. If any other forms or forced compliance have been used, rate 1.

**Question 15 – Cooperation with Treatment Providers**

If a client keeps appointments, but is not involved or is non-compliant with treatment efforts, rate 2. The modal rating for clients with several involuntary commitments in a defined period of time who are placed in a high intensity community service program is a 2.

**Question 16 – Alcohol and Drug Abuse**

Clinicians vary about what level of use comprises abuse for a chronically mentally ill person. Some believe that any use is abusive. The authors do not take this position. The item probes use to the extent that it interferes with functioning, which is a judgment of the clinician.

**Question 17 – Impulse Control**

One group's catch phrase was "If you'd hit your mother, you're a 1". Stabbing, breaking windows, flashing, setting fires are examples of poor impulse control in addition to those in the item. A rating of 2 is given to acts that are less severe, consistent, frequent, or to acts which were provoked, threats or intimidation without violence. A rating of 3 indicates less frequency than 2. A rating of 4 indicates perhaps one or two minor lapses of impulse control in the time period being rated. A rating of 5 indicates lack of noteworthy incidents.

**HOW TO SCORE THE MCAS**

Add the scores for each question for the section score, and add the section scores for the total scores. Do not assign a point count for any "don't know" used. Instead, prorate the section score (which will therefore prorate the total score) by 1) adding the scores for the items scored), dividing by the number of the items scored, and multiplying that figure by the number of items in the section. For example, if there are three items, one is scored 4, the second is scored 3, and the third is not scored, that is, it is marked "don't know", 1) add the two scores, which equal seven, 2) divide seven by two {the number of items

## Multnomah Community Scale Instructions

Page 5

scored}, which equals 3.5, and 3) multiply 3.5 X 3, which gives 10.5 as a section score. If you wish to round, by convention, we are suggesting rounding down to the nearest whole number, 10.

### NORMS FOR THE MCAS

The samples on which norms are based include clients from urban and rural areas. Since we have found little if any effect of location on the ratings, the urban and rural data are combined.

The clients were enrolled in community support units of community mental health centers. This enrollment implies that they suffer from a major mental illness (i.e. schizophrenia or bipolar disorder), have been hospitalized in the recent past or are at risk of hospitalization, and suffer from social role impairment in several areas. The samples include a slight preponderance of females. The clients' average age is slightly over 40.

### INTERPRETING THE MCAS

The groupings of scores in the table below are based on the normative data. The total score enables clinicians to compare their client's level of ability with that of the larger population of chronically mentally ill persons in the community. If the scale is completed each three to six months, over time a profile of client change can be obtained.

Sub-section scores can also be charted and compared to the norms of the same population. The sub-section scores provide more specific information about the client's ability because they indicate levels for areas of functioning embodying relative strengths or weaknesses of the client.

#### Levels of Ability

|         |                          |
|---------|--------------------------|
| 63 – 85 | High (little disability) |
| 48 – 62 | Medium                   |
| 17 – 47 | Low (severe disability)  |

**COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH  
COUNTYWIDE RESOURCE MANAGEMENT**

**Attachment II**

**Facility Satisfaction Survey**

Please take this opportunity to tell us how the services at the facility were effective in meeting your needs. We value any input that you give and we will take your feedback into consideration when making any plans to improve the quality and delivery of services.

The information that you provide will remain confidential and will not affect your services.

Name of Facility: \_\_\_\_\_

Your Length of Stay: \_\_\_\_\_

Please check the box that best describes your answer:

|   | Yes | Somewhat | No  |
|---|-----|----------|-----|
| 1) Did you like your treatment groups?  | [ ] | [ ]      | [ ] |
| 2) Were the groups helpful to you?  | [ ] | [ ]      | [ ] |
| 3) Was your care plan discussed with you?   | [ ] | [ ]      | [ ] |
| 4) Did you feel like your choices were considered in treatment and discharge planning?                    | [ ] | [ ]      | [ ] |
| 5) Did you feel that you learned to become self-sufficient in the community in preparation for discharge? | [ ] | [ ]      | [ ] |
| 6) During your stay, were you treated with respect?   | [ ] | [ ]      | [ ] |
| 7) Were your issues addressed in a timely manner by facility staff?                                       | [ ] | [ ]      | [ ] |
| 8) Overall, is this a place that you would recommend?   | [ ] | [ ]      | [ ] |

Please indicate your overall level of satisfaction with your stay at the facility by circling a number below:

|                      |   |   |                                   |   |   |   |                     |   |    |
|----------------------|---|---|-----------------------------------|---|---|---|---------------------|---|----|
| 1                    | 2 | 3 | 4                                 | 5 | 6 | 7 | 8                   | 9 | 10 |
| Not at all satisfied |   |   | Neither satisfied nor unsatisfied |   |   |   | Extremely satisfied |   |    |