Mental Health Services
Oversight & Accountability Commission

Client and Family Leadership Committee's Workgroup to Explore Outreach to Clients not Achieving Recovery

Issue:

Family members have experienced clients within their families languishing in the public mental health system, generally in Board and Care Homes that have led to on-going concerns because they are not moving towards recovery. This client group with severe mental illness is not being engaged in a way that the Mental Health Services Act (MHSA) intended for services to be available to help them achieve recovery.

Background:

The Mental Health Services Oversight and Accountability Commission's (MHSOAC) Client and Family Leadership Committee has created a Workgroup to explore outreach to clients not achieving recovery to fulfil one of its charter activities to review methods to engage individuals with serious mental illness who have not fully benefitted from MHSA services or reached recovery. The Workgroup convened five consecutive meetings throughout 2014. At the initial meeting, the Workgroup discussed the various metric tools used throughout California to measure recovery, and realized there is no required standardized approach being used statewide. It was then determined that the most meaningful and feasible contribution the Workgroup could consider was to inform what should be collected but currently is not. The suggestions brought forward from Workgroup members about how to improve information reported on persons receiving services also include some suggestions focused on improvements in services. The Workgroup decided to focus on specifics of what is currently collected for persons in Full Service Partnership (FSP) programs.

What follows are recommendations that emerged from the Workgroup.

Summary of Suggestions for Improving Data Reporting

1. Expand the types of information collected about a person's "discharge" from an FSP program. Suggestions included:
    - Add a data element that identifies whether a person is still receiving services and if so, what type of service. Was the person discharged to a lower level of care such as a Wellness Center?

- Add a data element that identifies where a person was living at time of discharge. An example would be:
    - With family member
    - independently
    - other
- Add a data element that provides a linkage to connect a client to another county if the county they will live in after discharge is a change from where they lived prior to discharge.
    - If the county is a different county, the added data element should collect information as to whether the client is referred to an FSP in the new county, based on information in their medical records.

- Add a data element that identifies if the client was unable to become engaged in recovery after a specific amount of time that includes what that amount of time is.

- Add a data element that identifies a person's level of recovery at discharge.
    - Currently there are no requirements for counties to report information about the level of a person's recovery. Some counties and programs do utilize various tools, however there is no uniformity among the counties or a standardized way being used that measures level of recovery. Some programs use tools that are completed by the provider, others may use separate tools to get both the provider's perspective and the client's perspective. The use of a uniform approach to measure the level of a person's recovery would help support better qualitative assessment strategies.

2. It was also noted that among the "administrative reasons for discharge from an FSP" are the following:
    - Client's circumstances reflect a need for residential/institutional mental health services such as an Institution for Mental Diseases (IMD) or Mental Health Rehabilitation Center (MHRC)
    - Client will be serving jail sentence
    - Client will be placed in juvenile hall/camp/ranch
    - Client will be placed in Division of Juvenile Justice

There was concern about this policy not being consistent with the goals for FSPs to continue to engage persons in institutional settings, including jails, so that they maintain a connection to the program and may return as soon as possible.

3. Add type of data element about whether a person is receiving peer services. An example would be:
    - Type of peer services, social, direct
    - Part of treatment team
    - Other

4. Add data element about whether a person has an interpersonal relationship/connectedness as a supportive system that supports recovery. This could be added to information collected at "baseline" (when a person enters an FSP) and/or reported with other information collected quarterly.) An example would be:

    - Primary relationship
    - Significant other
    - Friend
    - Family member reunite
    - Church or faith based/spiritual support
    - Other

5. Add data element about health status to quarterly reporting. Add data element about whether the person has been receiving services from a primary care provider. (This information may also apply to persons receiving traditional clinical services due to an on-going health issue or could be identified by an annual physical)

6. Add data element about whether "benefits" have been established to quarterly reporting. An example of types of benefits would be:

    - SSDI
    - Medi-Cal

Policy Considerations

Currently when a client is suspended from services, the system does not provide a mechanism for the client to come back at the same status level of recovery, upon return to services. There was concern that some FSPs have a specific number of "slots" available they must keep filled, even though the client filling the slot may not be willing to be engaged in services. There needs to be a way to collect data that captures if a client is "not achieving expectations for recovery" so services can be increased for those persons that are willing to engage and not just filling a slot.

System Flow and Policy Implications for Consideration

When a person is suspended from services, for whatever reason, they need to have the ability to come back. Traditionally, clients could come back, based on the FSP model, however if the suspension is perceived as "noncompliance", and the possible idea that the FSP is being reviewed for that, they may not want to report a suspension to limit accountability. The current discharge data reports the "partner separated", and the Workgroup suggests to consider terms such as "client values are not aligned" rather than "noncompliant" to more accurately convey why the client separated from services.

Suggestions Not Specific to Data Reporting

Some of the suggestions were not specifically about adding data elements to what is currently reported. Some of these comments included:

1. There was concern about the lack of "step-down" services available to persons leaving FSPs. It was noted that Los Angeles offers step-down services to persons based on their progress, but still considers the individuals as participants of an FSP, so they can easily return to access services if needed.

2. There was a question about what happens to a client's record if they go to another county. It was noted that counties would be required to have interoperability between each other in order to share mental health information contained in a client's electronic health record (EHR).

<u>Parking Lot:</u>

Track if connectivity is maintained when a person is placed out of county so when the client returns there is already established communication available for connectedness to continue.

Consider using Skype to support connectedness with others.