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COUNTY OF LOS ANGELES- DEPARTMENT OF MENTAL HEALTH

COMPTON MENTAL HEALTH
PHASE I ADULT SYSTEMS TRANSFORMATION

June 17, 2005

TO: Jim Allen
Deputy Director

Sandra Thomas
District Chief

FROM: Jackie Cox
Clinical Program Head

SUBJECT: **PROPOSAL**

Transitioning Case loads

During the initial phase 30 to 50 clients will be transitioned from a pool of 1200 existing cases with the identified teams involvement in the transition process. Admission criteria for Act programs will be used to determine the first 30 to 50 clients. Therapist and Case Managers will review cases for underserved within existing clientele:

- High use of psychiatric hospitals and/or psychiatric emergency rooms within the last year.
- High risk or recent history of criminal justice involvement
- Clients minimally responsive to traditional outpatient mental health services or has avoided utilization of these services
- Unable to consistently perform the range of practical daily living tasks required for basic functioning in the community and/or residing in substandard housing, homeless or at imminent risk if being homeless.
- MHA criteria for stages of recovery will be used to assist with the initial planning and transitioning of clients.

New consumer members/New staff

A letter has been drafted to all consumers receiving treatment in our center regarding the impending transformation to the recovery model. The single fixed point of responsibility (SFPR) will continue to meet with their clientele/members and assist them with the dynamics of the recovery model and look at the needs of each client on a continuum. Members that are determined to be at higher risk will be followed by the ACT team intensely. New staff and consumers will receive an orientation to the team concept of the recovery model.

Consumers who are closer to their recovery and wellness will be presented to the team preparing and transitioning for the upcoming wellness center. Existing members and new cases that present in this category will receive the initial engagement we will reference as fast tracking (ruling out right away the most expedient services for the consumers recovery).

Existing Programs

In an effort to transition as many clients into the recovery model all existing clinic programs particularly the dual diagnosis and healthy living programs will be quickly assessed for stages of recovery and integrated into the recovery model from the onset. All levels of functioning, as well as, age groups that particularly address issues for older adult and transition age youth will be a priority, as well. All new consumers meeting criteria for these programs will be fast tracked and engaged right away to receive services under the recovery model as they enter mental health services.

Stages of Recovery

All teams will assess for categories of consumers falling into recovery categories that have been established by the MHA Model. The Stage O: Unidentified which are clients experiencing distress, disruption, or wanting help with life. Being in a high risk group and experiencing early warning signs. This category will receive intense outreach and engagement by the recovery teams member addressing crisis and stabilization of consumers warranting mental health services.

Stage 1: Is the unengaged and these are individuals who have been identified in need of mental health services. These consumers are the individuals requiring crisis management, recovery support and possible sanctuary. The licensed professionals including the psychiatrist for medications will be paired with the unlicensed staff on the team to assist with the crisis interventions, case management, family issues and possible housing needs to keep the client stable in the community.

Stage 2: The consumers/individuals who have been engaged in mental health services and are welcoming collaboration in their own recovery. The medical case workers, substance abuse counselor, housing liaison, employment specialist and community workers will be greatly involved with the individuals in Stage 2 providing housing, financial, employment, education and community integration.

Stage 3: Are the self-responsible and are individuals that have the ability to coordinate their services; and they can set and pursue quality of life goals with minimal assistance. The recovery model team addressing community integration and attaining meaningful roles to graduate from the system will work with this group to ensure the members are

remaining medication compliant, maintaining their housing and receiving services to help become employed or remain employed.

Stage D: Are consumers who move away, move outside the public sector for mental health care or possibly loss to follow up. Certainly all individuals who improve and feel they no longer need mental health services, even if they do not reach their recovery will be reviewed for this category. All consumers who recover and graduate will be categorized for discharge, as well. This stage like all stages will allow for a continuum of care such as transfer between providers, re-engagement and relapse prevention if warranted.

Staffing Patterns

Multidisciplinary team approach with ratios of 12~15 clients per staff. The program will increase the number of teams as new staff are hired/added to transition the remaining consumers. As the teams grow the specialty units will grow to address: housing, community integration, employment and recovery/wellness activities. The first team will be comprised of:
75% of services will be outside of the clinical office setting.
1 Psychiatrist
1 Clinical Supervisor/Team Leader
1 Registered Nurse
1 PSW
1 Occupational Therapist (The current employment specialist)
1 Medical Case Worker (The current housing liaison)
1 Community Worker
1 Substance Abuse counselor
1 Peer Advocate

The psychiatrist is also a team member and will be responsible for routine and emergency medications (prn and/or increased agitation) for the initial 50 clients with a gradual expansion to 75 clients. He or she will provide clinical consultation to the team members. The psychiatrist will make home visits when warranted.

The supervisor or team leader will help to coordinate all services in the field. The supervisor or team leader will be responsible for up to five cases. The team leader will coordinate and review the team's records, documentation, provide signatures for LPHA documents, if warranted. He/she will provide ongoing review of the ability to enroll and/or discharge clients in or out of the ACT-Like programs.

The registered nurse will carry an active caseload of 12~15 clients. She will provide mental health services, medical and/or pharmaceutical therapy. The registered nurse may administer medications in the field. The MSW/PSW team member will carry an active caseload of 12~15 cases.

The medical caseworker (depending on experience with field outreach services) will carry a caseload of minimally 6 clients up to 10 cases. The occupational therapist, the community worker, substance abuse counselor and peer advocate will be active team members paired with other members on the team to provide community outreach services. Eventual increased staffing of peer advocates and volunteers will help to staff the wellness center.

Identified Hours of Coverage

All team members will be responsible collectively for managing the clients identified in the Act-Like program. The LPS staff will be the initial designated on call staff. The LPS will utilize the pager system 24 hours a day, 7 days a week (24/7) to respond to all calls, initially over the telephone. Most field face-to-face visits will be managed by the Act-Like team up to 6:00PM Monday through Friday. PMRT will assist with weekend face to face coverage, if warranted.

If it is necessary (PMRT can not provide the assistance) to manage a client after hours or the week ends the ACT team members (when scheduled) for after hour calls/coverage may be called to pair up with the LPS designee for an emergency field visit. Clinical team members will rotate weekly with on call supervision/responsibilities. All calls will be cleared with lead supervisor or manager on call. The PMRT/ACCESS unit will assist with after hour calls by telephone and face to face after 6:00PM Sunday through Saturday.

Needs/Alternatives: Standards of pay for on call (without field visit)
Standards of pay for only telephone interventions.
Standards of pay for actual field visit i.e. time and half pay for after hour field responses.
Flexible/modified work schedules.

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<u>Trainings/Meetings</u>

Teams will meet each morning or more regularly during the day if needed to discuss the status of existing and newly enrolled clients. Consultation with agencies practicing the model and ongoing immersion trainings should occur in the initial phase to offer support and empowerment to the staff who present resistant to the transformation changes. Immersion and recovery trainings remain supportive and empowering for all staff participating in the change to a recovery model. The community integration team members will have outreach pertaining to employment resources, housing, and other resources needed in the community to help keep clients stable and in their recovery.

Needs: Collaboration with other community organizations and/or hospitals to provide emergency services to ensure continuity of care.
Money management services
Housing developments/resources (low-income and/or subsidized units)