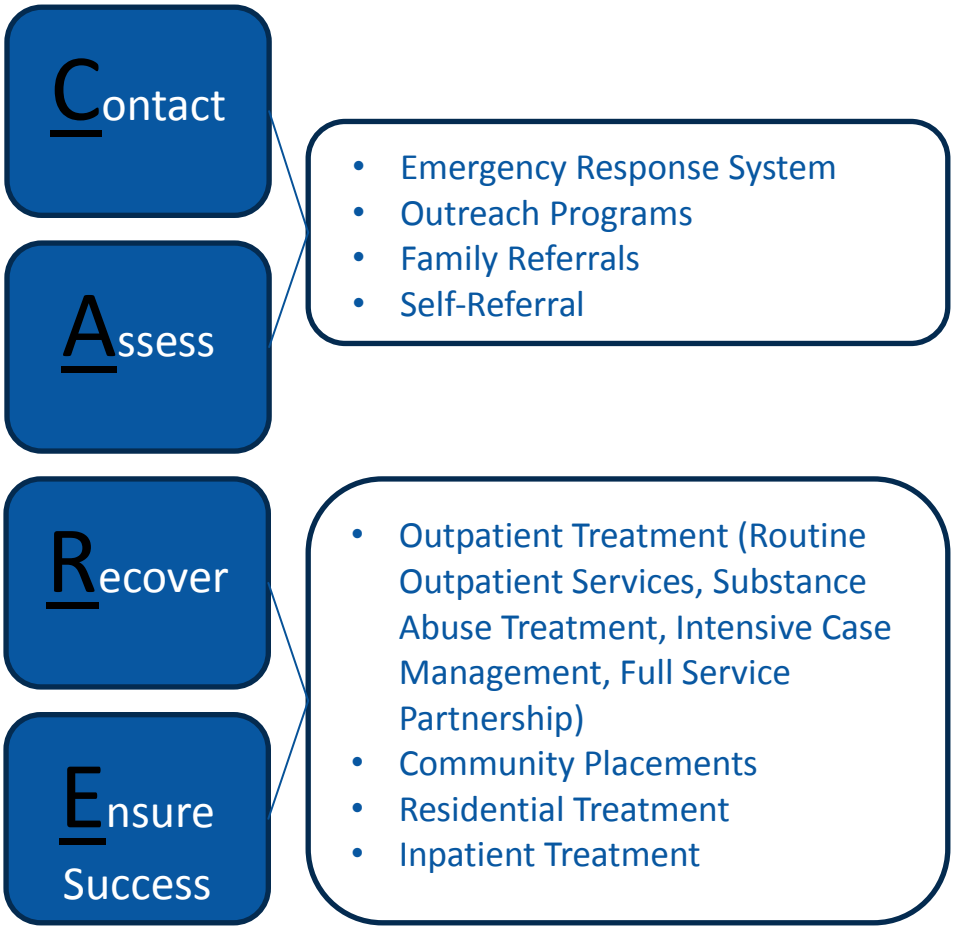
CARE Task Force
Sustaining Appropriate Treatment Along San Francisco's Continuum of Behavioral Health Care to Ensure Recovery and Success

OVERVIEW

Convened by the San Francisco Department of Public Health (SFDPH) at the request of Mayor Edwin M. Lee, the CARE Task Force will work to address the needs of severely mentally ill, and often dually diagnosed adults with behavioral health and substance abuse challenges that the current system has failed to adequately engage and successfully treat. As a result of its efforts, the Task Force will produce for Mayor Lee a range of policy and programmatic recommendations designed to fill gaps and overcome barriers that prevent the existing system from serving the CARE population effectively.

The graphic below captures Task Force goals as reflected in the group's name: Contact, Assess, Recover, and Ensure Success (CARE). The bulleted lists alongside the goals represent the possible mechanisms for achieving them via San Francisco's behavioral health system.



At its first meeting on March 20, 2014, the Task Force and members of the public engaged in a solution-oriented discussion of barriers known to prevent members of the CARE population from getting what they need to thrive. The second meeting of the Task Force on April 3, 2014, as well as a prior issue brief, focused on the Contact and Assess components of the Task Force's goals by discussing ideas for

identifying and engaging the CARE population. This brief will describe existing treatment approaches—both those currently offered by San Francisco's public behavioral health system as well as promising options from other jurisdictions —and explore the policy and programmatic aspects of the current system that must be maintained, expanded, or altered to successfully treat the CARE population and support them in recovery.

TREATING THE CARE POPULATION: A CONTINUUM OF CARE

In alignment with the federal Affordable Care Act's (ACA) mandate for wellness and recovery-oriented programming, the foremost principle guiding San Francisco's approach to behavioral health care is to provide tailored, appropriate treatment to clients in the least restrictive environment possible. The wellness and recovery model of care upholds the ideal that individuals can overcome serious mental illness and live more independent and productive lives. As such, programs and services are designed to provide individuals with the tools and support needed to successfully re-engage in their communities, attain individual goals, and live fulfilling lives. Integral to SFDPH's implementation of the wellness and recovery model are:

- Staff belief in and expectations of clients' potential for recovery, independence, and self-sufficiency;
- Clients' hope for and engagement with activities supporting their recovery and independence;
- Reliance on clients' natural community supports, including peer supports;
- Use of recovery-oriented assessment tools to identify and make use of clients' strengths that support achievement of their personal goals;
- Clients' management of their conditions and personal goals; and
- Transitions into lower levels of care, when appropriate.

The graphic on the following page captures the range of services available via San Francisco's behavioral health system. Available treatment options—in order from least to most restrictive—include outpatient services, community placements, residential treatment facilities, and locked inpatient facilities.

** These programs were discussed at the April 3, 2014 meeting of the CARE Task Force.*

The Task Force's goal is to find more ways meet the needs of the CARE population before restrictive treatment becomes necessary.

EXISTING CARE OPTIONS

Outpatient and Independent Living

Routine Outpatient Services Provide a Range of Behavioral Health Treatment Options to Individuals in the Community

A San Francisco Project in Process: Behavioral Health Homes

San Francisco plans to open four integrated behavioral health medical homes in 2014 pending approval of an ACA state plan amendment. As planned, these homes will embed primary care into behavioral health clinics. They will treat the whole person, managing and coordinating all of the services a person receives.

Routine outpatient services include a range of behavioral health treatment options that can be tailored to the needs of individuals with mental health and/or substance use issues. Such services may include, but are not limited to, assessment and evaluation, psychosocial case management, individual and group counseling, crisis intervention services, relapse prevention, medication management, vocational and educational classes. Designed to promote wellness and recovery, routine outpatient services help clients maintain independence and dignity while living in the community.

Wellness and Recovery Centers Promote Holistic Wellness and Community Connections

Wellness and recovery centers offer comprehensive mental health treatment services to empower clients with new opportunities and life skills in a positive, strengths-based environment. Centers provide clients with a range of service options that promote holistic wellness including peer support, groups, one-on-one counseling, and case management. As part of their model, wellness and recovery centers empower clients to take more responsibility for their own recovery: Peer services are largely consumer-driven, and group offerings stem from client feedback. In addition, clients may participate in group offerings without a provider referral/authorization. Through their comprehensive service offerings, wellness and recovery centers encourage and support clients in establishing connections in their communities to foster independence and esteem.

Intensive Case Management and Full Service Partnership Programs Play a Key Role in the Behavioral Health Service Continuum for Individuals with Serious Mental Illness

The primary purpose of **Intensive Case Management** (ICM) programs is to help clients in achieve stability while reaching personal life goals. The programs also seek to promote a sense of independence for clients so that they may improve the quality of their lives and establish meaningful roles in the community.

ICM case managers support their clients by:

- Conducting clinical assessment and developing treatment plans;
- Ensuring direct client involvement in all aspects of treatment planning;
- Helping coordinate client services across the behavioral health system;
- Providing medication management;
- Linking clients to community services and activities; and
- Providing ongoing support to maintain a caring and trustful relationship.

Program Capacity and Local Practice Hinder Representative Payee Services

San Francisco's Representative Payee Program serves clients who are unable to manage their own funds due to mental and/or physical impairment. A common service offering of ICM and other outpatient programs, payee services range from assistance applying for public benefits to monthly rent payment, enabling clients to secure and maintain housing. Payee services are also designed to support participants' wellbeing and independence. While the potential benefits of payee services are many, these services are not available to all who need them, as existing need for payee slots exceeds program capacity. In addition, even current capacity is not being maximized. Under local Social Security Administration practice, an individual must affirmatively elect to receive payee services even if a clinician, via Form SSA-787, has determined that individual is incapable of managing his/her income.

ICM and FSP programs differ from traditional case management models because of their low client-to-staff ratio: ICM/FSP staff typically has a caseload of 12 to 20 clients depending on the severity of clients' needs. In comparison, traditional case management typically involves caseloads of 60 to 100 clients per case manager.

Like ICM, **Full Service Partnerships** (FSPs) provide intensive wrap around case management services such as frequent outreach, daily medication management, crisis intervention, and peer support. Founded on the principle of doing "whatever it takes" to foster client recovery and success, FSPs differ from typical ICM programming in that they include a housing component and have "flexible funding," a financial support that can be used for items not traditionally covered by behavioral health funding, such as rental deposits, essential supplies, activity fees, books, and other items that help clients integrate into community settings. In providing such a wide range of interventions and resources, the FSP model is designed to support clients beyond stabilization to facilitate increased self-reliance, more meaningful lives and healthy connections with their communities.

70

Estimated number of people on waitlists for San Francisco's ICM and FSP programs.

Medication Assisted Treatment Minimizes Symptoms of Withdrawal, Supporting the Termination of Substance Abuse

Medication Assisted Treatment involves the use of medication proven to help individuals with substance use disorders to stop use of illicit drugs by reducing symptoms of dependence and withdrawal. Methadone maintenance for opiate addiction treatment is the most widely used treatment modality, but research shows additional medications (e.g., buprenorphine, naltexone, disulfiram, and acamprosate) are effective in treating addiction to various substances. Treatment generally involves daily oral medication combined with individual and group counseling. One medication is available in injectable form and is used to treat opiod or alcohol dependence.

San Francisco to Certify Medi-Cal Billable Intensive Outpatient Treatment Programs for Individuals with Substance Use Disorders

In California, the term "Intensive Outpatient Program" (IOP) has replaced that of "Day Treatment" as part of the Medi-Cal expansion under the ACA. (Medi-Cal is California's Medicaid program.) IOP requires client participation in program activities for a minimum of three hours three times per week. IOP activities include group and individual counseling, psychoeducation, and other recovery-oriented structured activities.

As part of ACA expansion, San Francisco is currently working to develop certified substance use disorder IOPs eligible for Medi-Cal reimbursement. Certification will represent a more intensive shift for both clients and providers, as the majority of existing outpatient treatment programs require a minimum of two scheduled sessions (primarily group treatment) per month.

Community Placements

Community Placements Ensure Housing While Residents Receive Support Services

Community placements refer to the middle section of the continuum of care – a critical bridge for people stepping down from residential or inpatient treatment as well as for those who need greater support than can be provided through outpatient services. While maintaining a stable living environment, residents have access to case management and treatment services that promote self-sufficiency. Housing options, which can be transitional or permanent, include cooperative housing, supportive housing, and residential care facilities. With the exception of residential care facilities, all community placement options noted here require that residents pay 30 to 50 percent of their monthly income toward rent. Each type of placement is described in more detail below.

Cooperative housing (co-ops) is the least restrictive community placement noted here. Operated by organizations such as Baker Places, Conard House, Progress Foundation, and HealthRIGHT 360, co-ops are shared living situations that provide social rehabilitation and clinical treatment. Clinical services are integrated with the program, in part, through outpatient services including case management, psychotherapy, and/or medication support. Residents care for themselves; however, residents must follow house rules, and an on-site counselor monitors behavior and mediates as necessary. Co-ops are a common placement for individuals coming out of transitional residential treatment facilities.

Supportive Housing is another core model of care for individuals who are homeless and often have co-occurring mental health issues, chronic substance abuse problems, and/or chronic medical conditions such as HIV/AIDS related issues. These individuals access housing and services through the San Francisco Human Services Agency's (SFHSA) Shelter Plus Care Program and the Single Room Occupancy Master Lease Program. Supportive housing is also available via SFDPH's Direct Access to Housing program as well as support hotels operated by a variety of entities.

- SFHSA operates the Shelter Plus Care (S+C), which offers housing and supportive services on a long-term basis for homeless people who have been residing at a shelter for an extended period of time. S+C provides subsidized rent in buildings owned or leased by nonprofit housing providers, and these nonprofit agencies offer support services such as case management, basic living skills training, representative payee and money management, benefits advocacy, support

groups, access to residential treatment, behavioral health services, crisis intervention, recreational activities, and vocational training.

- The Single Room Occupancy (SRO) Master Lease Program for adults funds operations and services at a number of additional permanent supportive housing sites for adults and/or families. The SRO Master Lease Program provides supportive housing for very low-income and homeless adults at SRO hotels that have been renovated and leased to nonprofit housing agencies. The nonprofit agencies have on-site case managers and provide property management, support services, and money management. More than 95 percent of all individuals placed in this program maintain housing stability from year to year.[1] This program does not maintain a waitlist, and referrals are made through pre-identified access points when there is a vacancy.
- SFDPH's Direct Access to Housing (DAH) supports low-income San Francisco residents who are homeless, high users of the public health system, and have co-occurring issues related to behavioral health, substance abuse, and/or medical problems. Housing options can include SRO hotels, units in new capital developments, set-aside DAH units in larger residential buildings owned by nonprofit providers, and units in residential care facilities. Residents live independently in private units and have access to on-site support services via case managers who provide one-on-one counseling for substance use and behavioral health issues. Case managers also help residents develop life skills and family relationships and assist residents with accessing outside behavioral health and substance abuse treatment as well as basic needs such as food and clothing. Since opening the first DAH site in 1999, almost two-thirds of residents have remained housed through the program.[2]
- Support Hotels, such as those managed by Conard House, provide hotel units to homeless adults living with chronic mental illness. They offer on-site counseling and case management. Services may also include: money management, representative payee services, and income advocacy services; health education; self-management training; and community events and groups. Residents are expected to manage their own basic needs regarding clothing, food, and medication. Responsible behavior related to alcohol and substance use is encouraged.

Principles of Supportive Housing

Although there are differences among supportive housing programs, all align with the four core principles of the supportive housing model:

- Permanence and Affordability
- Safety and Comfort
- Support Services are Accessible and Flexible and Target Housing Stability
- Empowerment and Independence

[1] Guide to Programs and Services (updated August 2011). City and County of San Francisco Human Services Agency. http://www.sfhsa.org/asset/ReportsDataResources/HSA_Guide_071312.pdf

[2] Delivering Innovation in Supportive Housing. http://dishsf.org/dah/direct-access-to-housing/

A Seattle Example: Harm Reduction Housing

Harm reduction houses are residential facilities for homeless adults suffering from chronic alcoholism. Residents have access to counselors; however, the houses are not considered treatment facilities and there is no expectation about reducing alcohol consumption. These harm reduction programs maintain the philosophy that if people are likely to engage in self-destructive behavior, living in a supervised environment reduces the potential harm of such behavior.

Seattle's 1811 Eastlake Housing First Program ("1811 Eastlake") has gained national attention for its effectiveness in lowering taxpayer costs while reducing alcohol consumption among its formerly homeless residents: One study of the program found that providing housing and on-site services to this population without requirements of abstinence or treatment was significantly more cost-effective than allowing them to remain homeless, saving taxpayers more than $4 million dollars over the first year of operation. The program realized these savings by reducing the time residents spent using publicly-funded services such as jail, hospital-based and emergency medical services, detox services, and other drug and alcohol programs. 1811 Eastlake also reduced resident alcohol consumption by one-third over the first 12 months.

Residential Care Facilities (RCFs), also known as board and care facilities, offer group living situations to those in the public behavioral health system that have complex behavioral health and/or medical conditions and lack appropriate alternative placements. RCFs provide greater assistance with meal preparation, medication monitoring, and personal care than is available in other types of community placements. RCFs are considered non-medical facilities. RCF residents abide by a curfew but do not otherwise have highly structured schedules.

A San Francisco Project in Process: Residential Care Facility

SFDPH is currently transitioning resources to replace 34 Skilled Nursing Facility beds with 59 RCF beds at its Behavioral Health Center (BHC). Leading to a total of 104 RCF beds at the BHC, this reallocation promotes the wellness and recovery model and aligns with SFDPH's commitment to prioritize the least restrictive environments that can effectively promote recovery.

Residential Treatment

Residential treatment programs are time-limited and provide a supervised environment in which clients receive treatment for acute behavioral health and substance abuse issues.

<u>Acute Diversion Units Provide a Short-Term Treatment Option for Acute Behavioral Health Episodes and Often Serve as a Gateway to Longer Term Residential Treatment</u>

Acute Diversion Units (ADUs) offer very short-term (24 hours to two weeks) crisis intervention treatment and rehabilitation for adults with major psychological disorders. ADU programs offer an alternative to hospitalization or locked inpatient facilities and can also serve as a "step down" from these more restrictive environments. ADU programs strive to develop clients' independent living skills and support network needed to increase their level of independence and reduce their use of emergency

services and inpatient treatment. Available services may include individual and group counseling, crisis intervention, peer support, assistance with activities of daily living, ambulatory medical support, and medication support. Services may also include referral to social services, vocational rehabilitation, primary care, housing, and community treatment.

Residential Treatment Provides Structured Programming to Support Wellness and Recovery

Both crisis-oriented and transitional residential treatment programs include a structured schedule of individual and group activities that help participants:

- Resolve immediate crises;
- Develop goal-oriented and time-limited treatment plans;
- Improve interpersonal skills; and
- Manage symptoms and medications.

Transitional Residential Treatment Programs Help Consumers Address Long-term Recovery Goals

In contrast to ADUs, transitional residential treatment programs provide longer-term care, ranging from three months to one year. These programs provide ongoing individualized support to allow clients to establish and maintain stability while focusing on long-term goals in their recovery. Transitional residential programs strive to prepare residents to successfully transition back to the community through the development of social skills and coping strategies as well as by providing access to resources such as permanent housing and ongoing outpatient care. As program participants typically present with a range of behavioral health and physical health needs, transitional residential treatment programs often include medical and substance use treatment components.

Residential Substance Abuse Treatment Programs Offer Recovery-Oriented Environment

Residential substance abuse programs offer participants a structured, supportive therapeutic residential community in which individuals can work through emotional difficulties as well as drug and/or alcohol addiction. These programs provide a continuum of chemical dependency prevention, treatment and recovery services in a recovery-oriented environment. The length of stay in a residential substance abuse program can be up to six months. As program participants typically present with a range of behavioral health needs, residential substance abuse treatment programs often include a mental health treatment component.

PRELIMINARY PROGRAMMATIC AND POLICY CONSIDERATIONS FOR TASK FORCE DISCUSSION

The CARE Task Force is an advisory body charged with developing a range of possible recommendations informed by data and community feedback. The full range of recommendations will appear in a final report directed to Mayor Edwin M. Lee for consideration. SFDPH presents below a series of policy and programmatic considerations that may inform both the Task Force's final report as well as San Francisco's broader behavioral health planning efforts. The considerations that follow also reflect Task Force discussion to date.

POLICY-LEVEL CONSIDERATIONS

State Level

- Support the implementation of the behavioral health home model as promoted in the Affordable Care Act state plan amendment.

Local Level

- Promote consistent enforcement of SSA-787 forms, the mechanism by which a physician recommends a patient for representative payee services, declaring him/her incapable of managing finances.

PROGRAMMATIC CONSIDERATIONS

- Place individuals in the least restrictive, most appropriate levels of care that promote rehabilitation, skill-building, and independent living.
- Increase the number of beds available in residential treatment programs.
- Increase the number of intensive case management slots to support more clients in outpatient settings.
- Increase opportunities for staff training across the behavioral health system on topics such as the wellness and recovery model, motivational interviewing, and treating dually diagnosed individuals.
- Increase access to wellness and recovery centers.
- Increase the use of peer specialists in treatment.
- Pursue a multidisciplinary, multi-departmental collaborative pilot project that utilizes informed patient consent to enable providers to share information to better engage clients and coordinate care planning.
- Increase opportunities for ongoing psychosocial support and education for families and caregivers per the San Mateo Family Assertive Support Team and San Diego In-Home Outreach Team programs.[3]
- Involve families in treatment plans whenever possible.

[3] These programs were discussed at the April 3, 2014 meeting of the CARE Task Force.

ACRONYM GLOSSARY

Acronym	Definition
ACA	Affordable Care Act
ADU	Acute Diversion Unit
BHC	Behavioral Health Center
CARE	Contact • Assess • Recover • Ensure Success (Task Force Name)
DAH	Direct Access to Housing
FSP	Full Service Partnership
ICM	Intensive Case Management
IOP	Intensive Outpatient Program
RCF	Residential Care Facility
S+C	Shelter Plus Care
SFDPH	San Francisco Department of Public Health
SFHSA	San Francisco Human Services Agency
SRO	Single Room Occupancy Hotel