PRESENTED BY STAFF FROM
ACCESS, IHOT, AOT, & CRISIS SERVICES
ACBH is a County Mental Health Plan

The Mental Health Plan (MHP) in each county is responsible for providing or arranging for the provision of Specialty Mental Health Services (SMHS) to Medi-Cal beneficiaries in their county.

SMHS means the impact of the beneficiary’s condition is severe enough for him/her to require the services of a specialist as opposed to a generalist in the field of mental health.
How Does Someone Access SMHS Services?

- **Call ACCESS (Acute Crisis Care and Evaluation for Systemwide Services) at 1-800-491-9099:**
  - Screening of eligibility for SMHS in Alameda County.
- **Common entry points into our system:**
  - Emergency Departments
  - Crisis Stabilization Units
  - Referrals from Family/Self through our ACCESS line (eligibility, screening, and referrals for specialty mental health services in Alameda County)
  - Substance Use Services
  - Other programs or services in the community
- **Those who do not qualify for SMHS (considered mild-to-moderate) are served by the Managed Care Plans (MCP) and private insurers:**
  - Alameda Alliance
  - Kaiser
  - Contact your private/commercial insurer customer service
System-wide point of contact for information, screening and referrals for mental health and substance abuse treatment & services for Alameda County residents from age 0 – 60+.

1-800-491-9099

Telephone service center staffed by licensed mental health clinicians and administrative support from 8:30am - 5:00pm, Monday – Friday.

Clinicians provide support for both general behavioral health questions and determine eligibility for a range of outpatient services.
ACCESS clinicians receive calls from consumers, friends/family, medical providers, social service representatives, law enforcement and many others.

A clinician will screen for eligibility, appropriateness of referral, and which delivery system the beneficiary should be served in, the county MHP and/or one of the Managed Care Plans (MCP).

ACCESS screening includes insurance eligibility.

Alameda County’s MHP is responsible for individuals who are Medi-Cal recipients, Medi-Cal eligible, Medi-Cal/Medicare recipients (Medi-Medi), HealthPAC recipients.
During an ACCESS screening, consumers and other callers may be administered a standardized screening tool and/or be asked to describe mental health concerns they have – including the severity of those concerns as well as the impact they have upon day to day functioning.

Signs and symptoms of concern may include thoughts, feelings, and behaviors (e.g., sadness, paranoia) that contribute to functional impairment.

- Ex: Auditory Hallucinations – repetitive voices that worsen w/ stress.
  - Functional Impairment: Cause increased isolation and avoidance of others which has led to transience/homelessness.
- Ex: Thought disorganization
  - Functional Impairment: can't reliably get to MD appointments or meet vocational goals.

Referrals for services are based on eligibility, the consumer’s mental health needs and provider availability.

ACCESS matches consumers to providers based on several factors including the consumer’s preference for a provider with a specific language/cultural background, provider’s gender, geographic location and provider’s clinical specialties.
General Resources

- **ACBH ACCESS Program**: 1-800-491-9099
- **Crisis Support Services of Alameda County (24-hour crisis line)**: 1-800-309-2131
- **ACBH Substance Use Access & Referral Helpline**: 1-844-682-7215
- **Managed Care Plans (Mild to Moderate Mental Health)**
  - Alameda Alliance for Health: 1-855-856-0577
  - Kaiser Oakland: 510-752-1075
  - Kaiser San Leandro: 510-626-2800
  - Kaiser Union City: 510-675-3080
  - Kaiser Fremont: 510-248-5050
What do I do when a client is unable or unwilling to connect with mental health services?
Consenting Services

- What does consent look like?
- Most appropriate level of care
- Psychiatry, medication support and therapy only
- Service Team:
  - Case manager
  - Face to face visits one to two times per month
  - Supported Employment Referral eligible. Individual Placement Supports (IPS)
- Full Service Partnership (FSP):
  - Highest level of outpatient care
  - Hospital without walls
  - Team approach and weekly face to face visits
  - Assertive Community Treatment (ACT)
What is an In-Home Outreach Team (IHOT)?

- Team consists of a Clinical leader/manager, a peer specialist, a case manager, and a family advocate.
- Purpose: Successful linkage to supports to avoid unnecessary hospitalizations and reduce interaction with the criminal justice system.
- Community engagement services to people who are reluctant to seek outpatient mental health services.
- Four mobile teams with an expected program census of 220 cases.
- IHOT places equal emphasis on supporting family members.
- One of the first steps for the AOT referral process.
Referrals
Please note: All referrals to IHOT go through ACCESS (1-800-491-9099). Name and Date of Birth needed to make a referral.

- Family members or caretakers
- PES
- Law Enforcement
- Jail
- Psychiatric Hospitals
- All Hospital Emergency Departments
- Mental Health Programs (Except for FSP and other outreach programs, exceptions may apply)
- Adult Protective Services
- NAMI and other advocacy agencies
What is Assisted Outpatient Treatment (AOT)?

- AOT is court-ordered treatment for individuals with severe mental illness in crisis and who are reluctant to seek treatment.

- **Purpose:** Prevent people from deteriorating to the point where they need to be involuntarily committed to a hospital.

- Civil matter and heard in civil court (not a criminal matter).

- AOT has great potential to reduce hospitalizations.
Who Qualifies for AOT?

- Per W&I Code 5345 – 5349.5 an individual must meet all of the following criteria to qualify for AOT:
  - The person is 18 years of age or older
  - The person is suffering from a mental illness as defined in paragraphs (2) and (3) of subdivision (b) of section 5600.3
  - 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:
    - The person’s mental illness has, at least twice within the last 36 months, been a substantial factor in necessitating hospitalization, or receipt of services in a forensic or other mental health unit of a state correctional facility or local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition
    - The person’s mental illness has resulted in 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, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition.
Who Qualifies for AOT? Continued.

- Per W&I Code 5345 – 5349.5 an individual must meet all of the following criteria to qualify for AOT:
  - 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
Some Things to Note About An AOT Investigation:

- Timelines – not a quick process, does not allow for involuntary commitment, is a lower level of care than a Conservatorship, time limited to 6 months but can be extended an additional 6 months.

- Be aware that information shared with Investigator can be used in Declaration.

- The best way to advocate for your loved one is to contact the IHOT Program assigned and provide as much information as possible, AB1424.

- Please note that IHOT Programs must also follow HIPPA on information sharing including referring parties – this may be a change for some families previously working with IHOT.
What are the Benefits of AOT?

- Full Service Partnership/ACT level of Care:
  - Individualized treatment plan
  - 24/7 Access to team
- Client maintains the Right to Refuse Treatment and Medication
- Experience from other counties – people engage in treatment without the court
What do I do if a client needs be hospitalized?
Crisis Services: Mobile Crisis Teams
Licensed clinicians providing mental health crisis intervention to children & adults throughout Alameda County

### Clinicians
Mobile Crisis Team (MCT)
- Countywide
- Crisis intervention
- 5150/5585 assessment
- **Diversion**
- Referral to a wide range of mental health & SUD services
- Currently: *Mon-Fri 8am-6pm*
- Dispatched via 911 or by calling (510) 891-5600

### Clinician & Officer
Mobile Evaluation Team (MET)
- Oakland and Hayward
- Crisis intervention
- 5150/5585 assessment
- **Diversion**
- Referral to a wide range of mental health & SUD services
- Currently:
  - Oakland: Mon-Thurs 8am-3pm
  - Hayward: Mon – Fri 8am-4pm
- Dispatched via 911 or by calling (510) 891-5600

### Clinician & EMT
Community Assessment & Transport Teams (CATT)
- Countywide
- Crisis intervention
- 5150/5585 assessment
- **Diversion**
- Referral & transportation to a wide range of mental health & SUD services
- 7 days a week 7:30 am-11pm
- Dispatched via 911
Outreach and Engagement Teams – Crisis Connect
Staffed by peers and others with lived experience

Referrals are received from:
- Mobile crisis teams
- Psychiatric emergency services (PES) at John George Psychiatric Hospital (In-Reaching)
- Service providers
- Schools
- Community members
- Self-referrals
- Willow Rock
- Children’s Hosp Oakland

Field & Phone Outreach
Care Coordination & Linkage
- Medi-Cal enrollment and/or county assignment updates
- Referrals
  - CRTs (Woodroe, Amber, Jay Mahler)
  - HSO (Harrison House, SoCo Homeless Project, Crossroads)
- Ongoing mental health services and follow up care
- Substance use treatment
- Other social services
Outreach and Engagement Teams
Staffed by licensed clinicians and a nurse
Mon-Fri 8:00-6pm, call (510)891-5600 for referrals / consultation

Geriatric Assessment & Response Team (GART)

- Provides brief voluntary behavioral health care services to older adults age 55+ with the aim of resolving mental health needs within 60 days through short term treatment and linkage to on-going behavioral health and community resources.
- The multidisciplinary team provides culturally aware, trauma informed, and age appropriate interventions.

GART Values:

- Independence
- Alternatives to Hospitalization
- Integrated Approaches to Care

GART Services:

- Crisis Intervention
- Evaluation and Assessment
- Consultation
- Short-term Case Management
- Brief Therapy
- Linkage to Long Term Care and/or Medication Support
- Community Outreach and Education
- Family Support and Education
How to contact ACBH Crisis Services to consult, request mobile crisis or outreach team?

Call us directly at (510) 891-5600 and ask for an on duty clinician who will determine the most appropriate team to respond.

Mon-Fri 8am-6pm

Voicemails received 24/7, and teams will follow-up the following business day.
Many calls are generated by law enforcement
We also receive referrals from individuals/community, other service providers, etc.
There are situations that require law enforcement and/or paramedics.

Call 911 for mental health emergencies involving imminent danger to self or others.

**Request a “CIT officer”**

(an officer who has had Crisis Intervention Training)

Have **AB 1424 Form** ready for officers when they arrive.

Provide as many relevant details as possible:

- What’s happening now?
- What do you or the person need?
- Any history with law enforcement?
- History of hospitalizations? Symptoms such as paranoia, or hallucinations, depression, violence, etc.
**SBAR for Consultation** - (510) 891-5600, ask for the on-duty clinician

**SBAR** is a clear and concise method used for conversations that require immediate attention and action. **SBAR** can also be used for non-urgent consultation or situations that require follow-up with an individual post crisis, or to address other chronic mental health issues.

- **Situation**
  - What’s happening?
  - “I’ve been working with a woman who’s been living in an encampment for 6 months. She appears to have mental health issues of concern. Others report that she is often talking to herself, in distress, dressed inappropriately and seems paranoid”.

- **Background**
  - What is the pertinent background information?
  - “She reports being homeless after her grandmother died last year. As a child she was in therapy and prescribed meds for childhood trauma”.

- **Assessment**
  - What is your assessment of the situation?
  - “She needs to be evaluated for hospitalization”. “She needs to be connected to care” “I’m not sure what she needs; she is not doing well overall”.

- **Recommendation**
  - What is your recommendation? “An outreach team that can link her to mental health services”.
  - What assistance do you need from Crisis Services? “Meet us at the location for a warm handoff”.

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**Call 911 for emergencies**
A 40 year old woman of Asian descent is referred by her therapist for having delusions of her mother poisoning her and monitoring her. The therapist initially referred the client to Mobile Crisis Team (MCT) for an evaluation, but MCT referred to Crisis Connect. When the Crisis Connect Mental Health Specialist follows up, the client is suspicious that she is an imposter and calls MCT to confirm her identity. A home visit is scheduled and the MHS notices holes in the walls of her apartment and the client is clearly moving towards grave disability.

What next steps would you take?
Crisis Connect Success Story

MHS Emily was able to schedule and conduct a home visit and build rapport with this client. Emily successfully referred her to on-going psychiatry and kept her on the Crisis Connect caseload to monitor her in case the psychiatry/medication management was not enough to support her. The medication was re-framed collaboratively by the client and Emily as the “antidote” to being poisoned by her mother, which led to higher levels of adherence. However, even with psychiatry and medication adherence, Emily determined that client was still unable to manage her mental health needs and client was securely linked to a service team for case management prior to discharge from Crisis Connect.
Questions???

Thank You!