Helping Older People Excel:
An Analysis of Marin County's HOPE Program

Kean Tan

EXECUTIVE SUMMARY

The HOPE Team is a multi-disciplinary team funded by Prop 63 and run by Community Mental Health. The team is designed to identify older adults whose safety and well-being are in jeopardy due to an Axis I mental health diagnosis. Older adults are often misdiagnosed with regard to mental illness, and it can be a challenge to accurately assess this population for co-occurring medical, psychological, and neurological issues. Members of the HOPE team provide intensive in-home treatment, therapy, and case management to keep at-risk older adults appropriately housed and safe in their communities. The program has been extremely successful, both in its collaborative capacity and in its ability to effectively address the needs of a chronically and historically difficult-to-serve population in Marin County.

Recommendations

In recent decades, San Francisco has been dealing with an intractable homeless problem. Since 2004, however, 1,679 formerly homeless single adults have been successfully housed through the San Francisco homeless plan. Among those housed, 94% are in desperate need of mental health services. I recommend expanding the San Francisco County's Diversion and Community Integration Program services to include intensive on-going support for the most hard-core and former chronically homeless people with mental health and drug addiction, by adopting best services from Marin County's HOPE program. It will provide the mental health services and support to help formally homeless people truly live off the street, remain housed, prevent re-institutionalization, and promote health and independence.

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Introduction

Society has historically tended to isolate and segregate individuals with disabilities. Despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem.

The independent living and disability rights movement led to the enactment of the Americans with Disabilities Act (ADA). The Act provides individuals with disabilities with equality of opportunity, full participation, independent living, and economic self-sufficiency without unfair and unnecessary discrimination and prejudice.

In 1999, two women with mental illness in Georgia sued the State of Georgia in the court case, *Olmstead v. Zimring* (119 S.Ct. 2176). They alleged that their continued institutionalization was a violation of their rights under the ADA. The United States Supreme Court concluded that states are obliged by the ADA to avoid unnecessary institutionalization and to provide a full array of services and programs to persons with disabilities so they can remain in their communities in the most integrated setting possible.

The independent living/disability rights movement, ADA, and the *Olmstead* Supreme Court decision have influenced California legislative and budgetary actions for more than two decades. The state is committed to adopting and adhering to service policies and practices that support the full integration of persons with disabilities into community life. This includes providing services for individuals who require assistance with activities of daily living. As a result, California has the largest consumer directed personal care program in the US, and has become the leader in the field.

While the ADA and the Olmstead Act are the driving force behind the independent living/disability rights movement in California and thereby lay the groundwork and set the regulations for services, other variable regional factors are also playing a major role in shaping, developing and delivering services for individuals with disabilities. Some of the most influential factors are demographic profiles, health trends, socio-economic status, and litigation.

San Francisco County's Diversion and Community Integration Program (DCIP) and Marin County's Helping Older People Excel (HOPE) are great illustrations. Both programs are in the same geographic region, serve the same hard to reach and at-risk population of individuals with disabilities, and have the same goals of ensuring that persons with disabilities have appropriate access and choice regarding community-based services and placement options; however, their approaches are very different. The BASSC program provided me with a great opportunity to observe Marin County's HOPE program; the learning experience has allowed me to develop recommendations for ways the City and County of San Francisco can enhance and expand its current DCIP program in a cost-effective way.

Marin County's HOPE Program: Marin's General Demographic

According to the Marin County Area Plan for Aging report for 2009–2012, the de-centennial census shows that Marin County's population is aging rapidly. In 2007, the median age among Marin County residents was 44.3 years. This ranks Marin County's population as the 6th oldest in California, a jump from its 13th place ranking in 2000. Persons ages 60

years or older in Marin are experiencing the biggest growth, at a rate of close to 41% from 2000 to 2010. By 2010, one in every four persons in Marin (25% of the county's total population) will be 60 years old or older. This boost is undoubtedly a result of the baby boomers joining the ranks of those over age 60 in Marin.

The aging of the population of Marin has only just begun; as a result, Marin County's attention to this segment of the population is particularly important. The most significant challenge for Marin County is counteracting the societal norm of older adults being disenfranchised and invisible: often, this invisibility is heightened if they have a mental health diagnosis.

Creation of the HOPE Program

Marin County's HOPE Program was created to promote the quality of life and independence of disabled and older adults, and to protect the health, well-being, self-sufficiency, and safety of older adults in Marin. It is designed for older adults age 60 and above, who are interested in participating in a program that will assess their living situations and address their emotional and physical needs. The HOPE program is capable of providing services beyond the scope of traditional mental health outpatient services.

How to Get into the HOPE Program

Many of the referrals for HOPE begin as referrals to Adult Protective Services (APS), but it was found that managing these cases through HOPE made for more successful outcomes.

The HOPE team members meet potential participants in their homes to assess their needs and determine how to best serve them. Many of Marin County's clients who are elderly and experiencing mental health issues are isolated and don't have access to reasonable transportation. During the home visit, the team members inquire about many components of the client's life, including assessing for any emotional health/emotional distress, psychiatric impairment, mobility issues, health issues, access to services, support systems, access to food, clothing and shelter, financial issues, substance abuse issues, self-neglect, and abuse issues.

Once they have determined a client's needs, team members make recommendations to the potential participant. The follow-up and referral recommendations fall under five possible categories:

- Senior Peer Counselor
- Intern Program
- Full-Service Partnership
- Referral to appropriate services (i.e., meals on wheels, community-based organization, physician, Alzheimer's association)
- Clients decline any services and no further follow-up needed

Senior Peer Counseling

Most of the clients who are served in the Senior Peer Counseling (SPC) program do not have a mental health diagnosis but are dealing with phase of life issues, grief or isolation. This program is not a companion program, but rather a program that focuses on emotional and health issues.

The SPC currently has about 40 peer volunteers who serve approximately 100 older adults in their homes. The counselors are retired professionals who go through eight weeks of training. After they graduate from the training program, volunteers are expected to attend one of the four weekly supervision groups that are offered. SPC matches counselors with clients and assigns one counselor to each client at the weekly supervision group. Once the couple is matched, the counselor does weekly home visits for as long as the client needs them.

Intern Program

Clients served in the Intern Program are assigned psychology interns who have chosen to receive extra training and experience working with older adults with disabilities. These interns offer a combination of home and office visits. Interns typically see clients who are clinically too challenging for a Senior Peer Counselor, but who do not qualify for a full-service partnership. They conduct weekly individual therapy for adults who have an Axis I or Axis II diagnosis

and who may have some functional impairment due to their diagnosis.

Full Service Partnership (FSP) (The Hope Program)

This Full Service Partnership (FSP) of the HOPE program is funded through the Mental Health Services Act (MHSA/Proposition 63). FSP uses a multi-disciplinary approach to work with hard-to-serve clients who have chronic and persistent mental illnesses. The multi-disciplinary team is comprised of social workers, a public guardian, a nurse practitioner, psychiatrists, and psychologists. It is staffed to serve 40 FSP clients. To qualify for the program, clients must meet the following admissions criteria:

- Clients must be over the age of 60; or, if they are at least age 55 and their psychiatric illness advances their age, they can qualify.
- Their primary diagnosis must be an Axis I diagnosis, ruling out organic and cognitive disorders, and if the primary diagnosis is substance abuse or dependency
- Clients must be currently either un-served, under-served, or inappropriately served.
- Clients must be at risk of homelessness, currently homeless, or in need of a higher level of care.

It is important to help those who need support so they are no longer isolated, fragile and alone. All services are home- and community-based, including the services provided by the nurse practitioner and the medical doctor. The HOPE program addresses all the needs and struggles that a client may bring forward. This includes addressing needs, such as psychiatric issues, medication, housing, financial concerns, physical health, family, substance abuse, activities of daily living, support systems, mobility, food, clothing, and transportation. HOPE program goals are to help clients remain as independent as possible and to foster trusting and caring relationships between team members and their clients.

History of San Francisco DCIP Unit

The creation of San Francisco's DCIP Unit is the result of two federal court class-action lawsuits, *Mark Chambers et al. v. City and County of San Francisco*, and *Davis et al. v. CHHSA et al.*, San Francisco, and joined by the Independent Living Resource Center (ILRCSF). In the Chambers lawsuit, the plaintiffs challenged San Francisco's discriminatory actions that had resulted in their unnecessary confinement at Laguna Honda Hospital (LLH). The plaintiffs are capable of, and would prefer, living in their own homes or in the community.

Both lawsuits helped San Francisco to assess and develop discharge plans for its current and potential Laguna Honda residents. The purpose of the DCIP unit is to provide an integrated approach to transition for individuals who are referred for admission to, and diversion and discharge from, LHH. The goal is to place individuals who desire to live independently in the community with the most integrated setting that will be appropriate to their needs and preferences.

The DCIP team has the authority to make recommendations and decisions about (LHH) admissions and discharges. The team also determines screening and eligibility for Long-Term Care and Short-Term Stay beds at LHH, as well as screening access to housing and other community-based services. All DCIP clients must be 18 years of age or older, and either currently admitted at LHH or discharged from LHH after January of 2008.

Recommendations for the City and County of San Francisco

San Francisco has been dealing with this intractable homeless problem for the past couple decades. Under the efforts of the current administration, 1,679 formerly homeless single adults have been successfully housed through San Francisco's 10 year homeless plan. Among those who have been housed, 94% are in desperate need of mental health services. Despite the successes of the homelessness program, the residents of San Francisco are still seeing and encountering aggressive panhandling and other unsavory behavior on the streets everyday by the formally homeless. Those who are housed are now in need of on-going support to stabilize their lives, get sober,

and find employment. The City and County of San Francisco needs to elevate its efforts to formally support homeless people to truly get off the street and prevent them from become homeless again.

San Francisco should adopt a modified version of the HOPE program that will expand DCIP to serve more than just Laguna Honda Hospital patients but also the most hard-core and chronically homeless individuals who have mental health and drug addiction problems.

Adopting Marin County's Peer Counseling Program would provide on-going emotional health support for formally homeless individuals. Additionally, the counselors are retired professionals who are at a point in their lives where they want to give back to their community; the Peer Counseling Program provides them with a transition from full employment into retirement. One idea would be to utilize the City and County's retirement planning system to offer retirees the opportunity to volunteer, as a way of helping them transition into retirement.

Adopting Marin County's Intern Program will provide housed residents with weekly individual therapy to help them stabilize their lives, get sober, and get off the streets. The psychology interns, who can be recruited from the Bay Area universities, can include those who are seeking to have extra training and experience in working with adults with mental health and drug addiction problems.

Cost/Budget Impact

The cost for the additional services will be minimal because retired professional volunteers and psychology interns under the supervision of the DCIP core group members from Laguna Honda Hospital (at no additional cost for supervision) can provide the new services.

The Peer Counseling and Intern Programs will reduce the total cost of homeless spending on hospital emergency treatment and the cost of enforcing laws for aggressive panhandling and other unsavory behavior on the streets. The program is also useful for preventing and reducing the return of offenders to local court systems and jails.

Proposed Action Steps to Implement the Peer Counseling and Intern programs

The following are proposed action steps for implementing the Peer Counseling and Intern Program:

- Coordinate a meeting between the HSA director, the DAAS director, and DCIP's core group members.
- Identify key players and providers in the homeless community.
- Collect data and analyze existing homeless services provided by DCIP and community agencies.
- Create and determine goals and outcomes.
- Analyze, modify, and adopt Marin County's HOPE program training manual, as well as procedures for the Peer Counseling and Intern Programs.
- Designate members for the newly-adopted Peer Counseling and Intern Programs.
- Determine program eligibility criteria.
- Create an implementation plan that includes recruitment and training of volunteers and interns.

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Resources

Marin County Community Mental Health Program, MHB Site visit questionnaire.

Marin County Area Plan For Aging 2009–2012.

The HOPE Program (Helping Older People Excel) Brochure.

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Chamber, et al. v. CCSF, Settlement Agreement.

San Francisco homeless 2009 survey responses.

SF Diversion and Community Integration Program (DCIP). One page operational process,