Laura's Law: Assisted Outpatient Treatment Demonstration Project Act of 2002

For the Reporting Period
May 2017 – April 2018

Department of Health Care Services
Community Services Division

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EXECUTIVE SUMMARY

Assembly Bill (AB) 1421 (Thomson, Chapter 1017, Statutes of 2002) established the Assisted Outpatient Treatment Demonstration Project Act of 2002 in Welfare and Institutions (W&I) Code Sections 5345 – 5349.5, known as Laura's Law. Laura's Law requires the Department of Health Care Services (DHCS) to establish criteria and collect outcomes data from counties that choose to implement the Assisted Outpatient Treatment (AOT) program and produce an annual report on the program's effectiveness, which is due to the Governor and Legislature annually by May 1. Additionally, DHCS is required to evaluate the effectiveness of the program strategies to reduce the clients' risk for homelessness, hospitalizations, and involvement with local law enforcement. This report serves as the May 1, 2018, annual report and provides outcomes for the May 2017–April 2018 reporting period.

During this reporting period, 19 counties have Board of Supervisors approval to operate an AOT program:

- Fifteen of the 19 counties submitted reports to DHCS;
- Four counties are in early stages of program implementation and did not submit a report;
- Of the 15 submitted reports, ten counties had data to report on AOT court-ordered or settled[1] individuals; and
- Five programs did not have court-ordered individuals or had too little data for the reporting year; however, information was provided on their programs' progress.

This report reflects aggregate outcomes for 142 individuals from the ten counties that reported court-involved[2] client data to DHCS. The number of participants more than doubled compared to the 2016-2017 reporting period, which included 63 court-involved individuals in AOT programs.

There are three important developments for this reporting period:

1. Four additional counties provided data on AOT court-involved clients as compared to 2016-2017;
2. Few individuals require court involvement to participate in AOT services

[1] Court "settled" means that the individual receives services through a court settlement rather than a hearing that would have resulted in a court order.

[2] Court ordered and settled individuals were combined, and are referred to as "court-involved" individuals or participants which will be dependent on the best flow in the context of this report.

as the majority enter into treatment voluntarily; and,

3. Aggregate outcomes indicated a positive impact on the three elements mandated by the statute governing AOT – homelessness, hospitalizations, and incarcerations.

Laws governing AOT programs require court-involved individuals to receive the same services as their voluntary counterparts. Individuals referred for an AOT assessment must first be offered voluntary services before a court petition is considered. For the current reporting period, 541 of the total AOT referrals responded to the initial invitation to participate in voluntary services. Counties report that this is due to a successful initial engagement process.

Due to the small number of court-involved individuals in each county AOT program, health privacy laws prevent DHCS from reporting specific numbers on each of the required outcomes. Using aggregated information[3] across the ten county's AOT programs, the following reflects key highlights for this reporting period:

- Day's homeless decreased;
- Hospitalization decreased by 29 percent[4];
- Contact with law enforcement decreased by 16 percent;
- Fifty-Six percent of individuals remained fully engaged with services ;
- Some individuals were able to secure employment;
- Victimization[5] was reduced by 90 percent;
- Violent behavior decreased by 80 percent;
- Clients presenting with a co-occurring mental health and substance use disorder reduced substance use by 6 percent
- Fourteen percent of total participants were subject to enforcement mechanisms;[6]
- Most counties reported improvements in clients social functioning and independent living skills; and,
- Client and family satisfaction surveys indicated high levels of satisfaction with AOT services.

[3] Aggregate information includes available data for each element reported by counties. Los Angeles, Ventura, and Yolo County did not provide data for one or more elements.

[4] Descriptions of each element's outcome is calculated by percentage change to represent the degree of change during AOT from prior to the individual entering the program.

[5] Victimization is often underreported and based on varying definitions.

[6] Examples of enforcement mechanisms include, but are not limited to, involuntary evaluation, increased number of status hearings, and medication outreach.

DHCS' analysis of the AOT program participants served during this reporting period suggests improved outcomes. The numbers of individuals participating in AOT services statewide has increased since more counties have implemented programs. Notably, almost 80 percent of individuals referred for an assessment opted to engage voluntarily. The ongoing efforts to develop robust engagement and support strategies is seemingly responsible for high involvement and voluntary participation in AOT. With continued success in this area, programs are likely to maintain low numbers of individuals that require court involvement. Data indicates that AOT and program support are contributing factors in helping clients to avoid or reduce hospitalization, homelessness and incarceration. Given these positive outcomes, DHCS recommends the continuous monitoring of AOT programs implemented under Laura's Law.

BACKGROUND

AB 1421 (Thomson, Chapter 1017, Statutes of 2002) established the Assisted Outpatient Treatment (AOT) Demonstration Project Act of 2002, known as Laura's Law. AOT provides for court-ordered community treatment for individuals with a history of hospitalization and contact with law enforcement. The Law is named after a woman who was one of three people killed in Nevada County by an individual with mental illness, who was not following his prescribed mental health treatment. The legislation established an option for counties to utilize courts, probation, and mental health systems to address the needs of individuals unable to participate in community mental health treatment programs without supervision. In 2008, the first AOT program was implemented in Nevada County. In 2012, program oversight was transferred from the former Department of Mental Health to the Department of Health Care Services (DHCS) and incorporated into DHCS' county mental health performance contracts[7] with the enactment of SB 1009 (Committee on Budget and Fiscal Review, Chapter 34, Statutes of 2012). AB 1569 (Allen, Chapter 441, Statutes of 2012) extended the sunset date for the AOT statute from January 1, 2013, to January 1, 2017.

The statutory requirements do not require counties to provide AOT programs and do not appropriate any additional funding to counties for this purpose. Nevada County operated the only AOT program until the passage of SB 585 (Steinberg, Chapter 288, Statutes of 2013), which authorized counties to utilize specified funds for Laura's Law services, as described in Welfare & Institutions Code (W&I) Sections 5347 and 5348. Since the enactment of this legislation, an increasing number of counties have implemented AOT. The sunset date was again extended until January 1, 2022, with the enactment of AB 59 (Waldron, Chapter 251, Statutes of 2016) which also added the Governor as a direct recipient of this report.

In California, 19 counties have or are in the early stages of implementing AOT. Currently, 47 states and the District of Columbia have AOT program options (some states refer to it as "outpatient commitment"). See Appendix for more information on the development of AOT in California.

INTRODUCTION

DHCS is required to report to the Governor and Legislature on the effectiveness of

[7] DHCS county mental health performance contracts became effective July 2013.

AOT programs annually by May 1. Pursuant to W&I Code Section 5348, effectiveness of AOT programs is evaluated by determining whether persons served by these programs:

- Maintained housing and participation/contact with treatment;
- Have reduced or avoided hospitalizations; and
- Have reduced involvement with local law enforcement, and the extent to which incarceration was reduced or avoided.

To the extent data is provided by participating counties, DHCS must also report on the following:

- Contact and engagement with treatment;
- Participation in employment and/or education services;
- Victimization;
- Incidents of violent behavior;
- Substance use;
- Required enforcement mechanisms;
- Improved level of social functioning;
- Improved independent living skills; and,
- Satisfaction with program services.

The AOT statute provides a civil process for designated individuals who may refer someone to the county mental health department for an AOT petition investigation. In order for an individual to be referred to the court process, the statute requires certain criteria to be met, voluntary services to be offered, and options for a court settlement process rather than a hearing.

Participating County Implementation and Reporting Status

Table 1 provides a list of counties that have received Board of Supervisors approval to operate an AOT program, counties that submitted an AOT report to DHCS for this reporting period and, of those, which counties served AOT court-involved individuals.

Table 1. Participating County Implementation and Reporting Status

County	Board of Supervisor Approval	Submitted a Report to DHCS	Served Court-Involved Individuals
Alameda	X	X	X
Contra Costa	X	X	X
El Dorado	X	X	
Kern	X	X	
Los Angeles	X	X	X
Marin	X		
Mendocino	X	X	X
Nevada	X	X	X
Orange	X	X	X
Placer	X	X	
San Diego	X	X	
San Francisco	X	X	X
San Luis Obispo	X		
San Mateo	X	X	X
Santa Barbara	X	X	
Shasta	X		
Stanislaus	X		
Ventura	X	X	X
Yolo	X	X	X

DATA COLLECTION AND REPORTING METHODOLOGY

Most counties have implemented their AOT programs as part of their Mental Health Services Act (MHSA) Full Service Partnership (FSP) programs. W&I Code Section 5348(d) sets forth the reporting requirements for both the counties and the state and lists the required data elements that, if available, must be included. As a result, counties obtain data for AOT clients from some or all of the following sources:[8]

- Client intake information;
- MHSA FSP Outcome Evaluation forms:
  - Partnership Assessment Form – The FSP baseline intake assessment;
  - Key Event Tracking (KET) – Tracks changes in key life domains such as

[8] Counties utilize additional tools including, but not limited to, pre-established assessments; program developed surveys; and internal data sources (e.g. billing, staff reports, etc.). Sources listed in this report do not fulfill all required or the same data elements by counties.

employment, education, and living situation;
    - Quarterly Assessment – Tracks the overall status of an individual every three months. The Quarterly Assessment captures data in different domains than the KETs, such as financial support, health status, and substance use;
- "Milestones of Recovery Scale" (MORS) ;[9] and
- Mental Health Statistics Improvement Program Consumer Surveys – Measures components that are important to consumers of publicly funded mental health services in the areas of access, quality, appropriateness, outcomes, overall satisfaction, and participation in treatment planning.

Counties collected and compiled the required information into written reports, which were submitted to DHCS. Due to the small population sizes reported, AOT clients may be identifiable. DHCS is committed to complying with federal and state laws pertaining to health information privacy and security.[10] In order to protect clients' health information and privacy rights, some numbers for each of the specified outcomes cannot be publicly reported. In order for DHCS to satisfy its AOT program evaluation reporting requirement, as well as protect individuals' health information, DHCS adopted standards and procedures to appropriately and accurately aggregate data, as necessary. Therefore, data reported is in aggregate numbers.[11]

FINDINGS FOR REPORTING PERIOD May 1, 2017 – April 30, 2018

Based on county-reported data, of the total 683 AOT referrals, 541 responded to the initial invitation to voluntary services, and did not require a court petition or process. Counties report that this is due to a successful initial engagement process, as most individuals referred for assessment accept the first offer for voluntary services. Programs served 142 individuals that entered AOT programs as a result of court orders or

[9] This scale was developed from funding by a Substance Abuse and Mental Health Services Administration grant and designed by the California Association of Social Rehabilitation Agencies and Mental Health America Los Angeles researchers Dave Pilon, Ph.D., and Mark Ragins, M.D., to more closely align evaluations of client progress with the recovery model. Data collected from the MORS is used with other instruments in the assessment of individuals functioning level in the Social Functioning and Independent Living Skills sections. Engagement was determined using a combination of MORS score improvement, contact with treatment team tolerance and social activity.

[10] Federal laws: Privacy Rule and the Security Rule contained in the Health Insurance Portability and Accountability Act and clarified in Title 45 Code of Federal Regulations Part 160 and Subparts A and E of 164. State Laws: Information Practices Act and California Civil Code Section 1798.3, et. seq.

[11] Percentages derived from totals are rounded to the whole numbers throughout the report.

settlements.

Although 19 counties have implemented AOT programs, the data summarized in this report reflect the ten counties that served court-involved individuals. Data for these counties are aggregated, with highlights of each program listed first. The ten counties' AOT programs collectively served a total of 142 court-involved individuals. This is more than double the number of participants served during the 2016-2017 reporting period, in which 63 individuals were court-involved.

County Highlights

Alameda County has more than doubled its capacity in the last two years for its three AOT programs – In-Home Outreach Teams, Community Conservatorship, and AOT.

Contra Costa County is in its second year of providing AOT services and utilizes a Care Team that includes staff from Contra Costa Behavioral Health Services, Forensic Mental Health and Mental Health Systems Assertive Community Treatment Team (contracted mental health organization). Contra Costa reports working collaboratively with both criminal justice and community stakeholders.

Los Angeles County reported serving voluntary clients since 2010 in a pilot AOT program, then fully implemented and expanded in 2015. This is their second year reporting on court-involved AOT individuals which represents a fraction of its overall number of AOT participants.

Mendocino County recently began their AOT program with this being their first year reporting court-involved individuals.

Nevada County has the longest running AOT program, dating back to 2008. Consistently over time, the majority of the referred individuals accepted the program's invitation to participate in voluntary services rather than requiring a court process.

Orange County noted that at least a third of the individuals completing their AOT program continued on with mental health services voluntarily. In addition, the county also reported that some individuals enrolled in college or vocational school.

San Francisco County has developed an AOT Care Team, which is responsible for AOT court petitions and advocating for AOT individuals with pre-existing charges to be referred to collaborative courts, such as Behavioral Health Court. Behavioral Health Court is focused on family support, and offers a Family Liaison to provide resources

and assistance with navigating the mental health and criminal justice systems. San Francisco County continues to host a quarterly conference call with other counties that have implemented AOT to share information and experiences.

San Mateo County assembled a team consisting of clinical and psychiatric staff, a Deputy Public Guardian and peer support workers that travel throughout the county to evaluate individuals and provide referrals to services, as needed. Additionally, a peer support worker is dedicated to enhancing engagement efforts and to provide support to individuals encountering the AOT program.

Ventura County calls its AOT program "Assist," and one of its goals is to reach out to unserved individuals in the Latino/Hispanic community, which comprises nearly 41 percent of Ventura County. The AOT team includes bilingual and bicultural staff to assist with connecting to individuals who may be in need of AOT.

Yolo County began with a pilot program in 2013 which was made permanent in 2014. The county has mainly served voluntary individuals and this year, reported for their first time on a small number of court-involved individuals.

Findings

Demographic Information

Mirroring the 2016-2017 reporting period, the majority of participating individuals were Caucasian males between ages 26 and 59, although counties report seeing more racial and gender diversity in their AOT populations.

Table 2. Demographics of AOT Court-Involved Individuals[12,13]

DEMOGRAPHIC	TOTAL AOT PARTICIPANTS	% OF TOTAL
COURT PROCESS TYPE		
Court Order	50	35%
Court Settled	92	65%
TOTAL	142	100%
Sex/Gender		
Female	52	37%
Male	86	61%
TOTAL	138	100%
Age Categories		
18-25	^	^
26-59	83	87%
60+	^	^
TOTAL	95	100%
Race/Ethnicity		
Caucasian/White	57	41%
Black/African American	17	12%
Hispanic/Latino	32	23%
Native American	^	^
Asian	^	^
Hawaiian/Pacific Islander	^	^
Other	19	14%
TOTAL	140	100%

[12] Totals include available data for each element reported by counties. Los Angeles, Ventura, and Yolo County did not provide data for one or more elements.

[13] ^ Data has been suppressed for privacy protection.

Homelessness/Housing

In the 2016-2017 reporting period, counties reported modest reductions in homelessness, with the majority of clients obtaining and maintaining housing while in the AOT program. For this reporting period, counties reported static levels of homelessness for both prior to and during the program, which held at approximately 50 percent. Some counties noted that individuals who experienced housing instability during the program, were homeless a fewer number of days than they were prior to the AOT program.

Hospitalization

In the 2016-2017 reporting period, most programs reported clients with psychiatric hospitalizations either reduced their days of hospitalization or entirely eliminated hospitalizations while in the program. In this reporting period, overall hospitalization was reduced by a 29 percent change during AOT, as compared to prior to the program.

Law Enforcement Contacts

In the 2016-2017 reporting period, all programs reported reductions in law enforcement contact for participants in AOT programs. For this reporting period, law enforcement contacts were reduced by 16 percent change during AOT, as compared to prior to the program. Moreover, some counties reported reductions in the number of days incarcerated per individual.

Treatment Participation / Engagement

Each county provides data on AOT individual's adherence to treatment and whether or not they maintained contact with their program. The treatment participation and engagement section of this report is comprised of these two required data elements.

For the 2016-2017 reporting period, the majority of the participants were able to engage in treatment and remain in contact with their programs. For this reporting period, counties continue to report that the majority of individuals adhered to their treatment plans and continued engagement with AOT services.

Employment

For the 2016-2017 reporting period, there was an increase in employment for individuals across programs, including some participation in education. For this reporting period, that trend continues, with four of the ten counties reporting

employment for some program participants. Three additional counties reported individuals working toward achieving their high school diploma, attending college or vocational school, or participating in employment services.

Victimization

In the 2016-2017 reporting period, there were few reports of victimization, with some counties reporting that individuals were reluctant to share such information via the questionnaires utilized. These counties indicated that they would modify their questionnaires, the questionnaire collection process and/or therapeutic environment to provide more comfortable means for individuals to share such sensitive information. In this reporting period, counties reported victimization was reduced by a 90 percent change percent during AOT, as compared to prior to the program.

Violent Behavior

In the 2016-2017 reporting period, some programs reported violent episodes for individuals who were struggling with the initial phases of the program, while other programs reported that the AOT program participants displayed decreased violent behavior. In the current reporting period, programs reported a decrease in violent behavior by an 80 percent change during AOT, as compared to prior to the program.

Substance Abuse

The majority of individuals in AOT have co-occurring diagnoses, meaning that they have both a mental health and substance use disorder. This presents complications for programs to support individuals in the AOT program because concurrent treatment is needed. For the 2016-2017 reporting period, all programs reported varying levels of challenges with participant substance use. Some counties reported that the majority of individuals relapsed during AOT, while other counties reported that the majority were able to avoid substance use.

During the current reporting period, substance use was reduced by 6 percent during AOT, compared to prior to the program. Counties report that many individuals are reluctant or not forthcoming with this information and may underreport use.

Enforcement Mechanisms

Counties define enforcement mechanisms differently but tend to include increased number of update hearings, medication outreach, and/or assessments for potential hospitalizations. For the 2016-2017 reporting period, the most common enforcement

mechanisms used were additional status hearings, with few individuals receiving orders for hospitalization for the purpose of psychiatric evaluation. During the current reporting period, three counties reported the use of enforcement mechanisms, which represented 14 percent of the total individuals reported on.

Social Functioning

For the 2016-2017 reporting period, AOT programs reported increased social functioning. The participants' ability to interact with staff and tolerate therapeutic interactions was noted as a significant outcome. During this reporting period, eight of the ten counties conveyed that similar improvements were made by all individuals.

Independent Living Skills

In the 2016-2017 reporting period, programs reported an improvement in the majority of individual's independent living skills. Additionally, individual's demonstrated strengthened skills in stress management and food preparation, improved hygiene, and ability to utilize transportation. Counties noted similar improvements during this reporting period.

Satisfaction with Services

For the 2016-2017 reporting period, the majority of surveyed individuals reported satisfaction with their services. During this reporting period, six of ten counties surveyed AOT participants and their family members. Responses demonstrated overall satisfaction with the AOT program.

DISCUSSION

County data suggest several benefits of participation in AOT programs. Prior to AOT, many individuals' experienced mental health treatment that involved locked facilities or hospitalizations. Upon entering the AOT program, many clients adjusted to forming relationships with support staff and receiving intensive services outside of a locked setting. The success of this adjustment was indicated by the majority of individuals maintaining contact with their programs and treatment engagement. A notable challenge was individuals served with co-occurring disorders that required a great deal of program support. As a result, some counties reported challenges with participants relapsing, which lead to further psychiatric hospitalizations, and underreported substance use. Despite challenges, data indicated a slight reduction in substance use. Additionally, court-involved individuals only comprise 32 percent or less of total AOT program populations (voluntary and involuntary) for each county. This suggests that

programs are maintaining strong engagement efforts to avoid the court petition process.

LIMITATIONS

There are several noteworthy limitations of DHCS' analysis. The statewide total of court-involved clients remain small, making it difficult to determine statistically significant conclusions. Additionally, counties are not using standardized measures or reporting periods, which makes cross-county analysis challenging. Further, there is no comparison and/or control group[14] therefore, improvements cannot be exclusively linked to AOT program services. Some of the measures are based on self-reports and/or recollections of past events, which may or may not be accurate or reliable. Moreover, individuals enter AOT at varying times, resulting in carry-over data from prior reporting periods. Despite these limitations, DHCS' analysis suggests improved outcomes for the AOT program participants served.

CONCLUSION

The aggregate outcomes of the 142 court-involved individuals, served across ten counties, indicated success in reducing homelessness, hospitalizations, and incarcerations for the 2017-2018 reporting period. DHCS recommends continued monitoring of the effectiveness of AOT services, as counties continue to develop, expand, and/or implement these programs.

[14] Statue does not require counties or DHCS to evaluate data on voluntary participants.

APPENDIX

History of Involuntary Treatment and the Development of Laura's Law in California

Among significant reforms in mental health care, the Lanterman-Petris-Short (LPS) Act (Chapter 1667, Statutes of 1967) created specific criteria by which an individual could be committed involuntarily to a locked inpatient facility for an assessment to eliminate arbitrary hospitalizations. To meet LPS criteria, individuals must be a danger to themselves or others, or gravely disabled due to a mental illness (unable to care for daily needs). Following LPS, several state hospitals closed in 1973 to reduce the numbers of individuals housed in hospitals. The intention was to have communities provide mental health treatment and support to these discharged patients. However, due to limited funding, counties were unable to secure the resources necessary to provide adequate treatment or services. As a result, many of the individuals released from the hospitals became homeless or imprisoned with very little or no mental health treatment.

In 1999, the state of New York (NY) passed Kendra's law,[15] after Kendra Webdale was pushed in front of a subway train. A man with a long history of severe mental instability and multiple short stints of hospitalizations was responsible for her death. The law authorized court-ordered AOT for individuals with mental illness and a history of hospitalizations or violence. Additionally, this required participation in appropriate community-based services to meet their needs. Kendra's Law defines the target population to be served as, "…mentally ill people who are capable of living in the community without the help of family, friends and mental health professionals, but who, without routine care and treatment, may relapse and become violent or suicidal, or require hospitalization." NY requires the program to be implemented in all counties and gives priority services to court order individuals. Patterned after Kendra's Law, California passed Laura's Law AB 1421 (Thomson, Chapter 1017, Statutes of 2002).

[15] For additional information, see New York's Office of Mental Health website