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

For the Reporting Period
May 2018 – April 2019

Department of Health Care Services
Community Services Division

March 2020

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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 data outcomes 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 programs' strategies to reduce the clients' risk for homelessness, hospitalizations, and involvement with local law enforcement. This report serves as the May 1, 2019, annual report and provides outcomes for the May 2018–April 2019 reporting period.

Previous Reporting Period Key Highlights

During the previous reporting period (2017-2018), the following highlights reflect aggregate outcomes[1] for 142 individuals from ten counties that served court-involved[2] clients:

- Days of homelessness decreased;
- Hospitalization decreased by a 29 percent change[3];
- Contact with law enforcement decreased by a 16 percent change;
- 56 percent of individuals remained fully engaged with services;
- Some individuals were able to secure employment;
- Victimization[4] was reduced by a 90 percent change;
- Violent behavior decreased by 80 percent change;
- Clients presenting with a co-occurring mental health and substance use disorder reduced substance use by a 6 percent change;
- 14 percent of total participants were subject to enforcement mechanisms[5];
- 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.

[1] Aggregate outcomes includes available data for each element reported by counties.
[2] "Court-involved" refers to the individuals that received services through a court petition. Petitioned individuals may waive their right to an AOT hearing that would result in a court order and receive services through a court settlement. "Court-involved" individuals or participants are used interchangeably; which will be dependent on the best flow in the context of this report.
[3] 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.
[4] Victimization is often underreported and based on varying definitions.
[5] Examples of enforcement mechanisms include, but are not limited to, involuntary evaluation, increased number of status hearings, and medication outreach.

2018-2019 Key Highlights and Developments

This report reflects aggregate outcomes for 228 individuals from 13 counties that reported court-involved client data to DHCS. The following reflects key highlights for this reporting period:

- Homelessness decreased by a 30 percent change;
- Hospitalization decreased by a 33 percent change;
- Contact with law enforcement decreased by a 43 percent change;
- Some individuals were able to secure employment or obtain volunteer positions;
- Victimization was reduced by an 85 percent change;
- Violent behavior decreased by a 64 percent change;
- Clients presenting with a co-occurring mental health and substance use disorder reduced substance use by a 34 percent change;
- Most counties reported improvements in clients social functioning and independent living skills; and,
- Client and family satisfaction surveys indicated satisfaction with AOT services.

There are four important developments for this reporting period:

1. Three additional counties provided data on AOT court-involved clients as compared to 2017-2018;
2. 25 percent of total individuals required court involvement to participate in AOT services, with the majority entering into treatment voluntarily;
3. 60 percent of petitioned individuals received services through a court settlement; and,
4. Aggregate outcomes indicated a positive impact on the three elements mandated by the statute governing AOT – homelessness, hospitalizations, and incarcerations.

DHCS' analysis of the AOT program participants served during this reporting period, suggest improved outcomes. The numbers of individuals participating in AOT services statewide has increased since all implemented counties have a court petition process in place.[6] The ongoing efforts to develop robust engagement and support strategies, is seemingly responsible for high involvement and voluntary participation in AOT. Notably, 75 percent of individuals referred for an assessment, opted to engage voluntarily. With continued success, numbers of individuals requiring court involvement are likely to remain low. Data indicates AOT and program support are contributing factors in helping clients avoid or reduce hospitalization, homelessness, and incarceration.

[6] Due to this inflation, DHCS is unable to accurately evaluate program effectiveness across multiple years.

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. Laura's 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 (see Appendix B for patient criteria and referral process). 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 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 statute does not require counties to provide AOT programs, and does 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 W&I Code 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. See Appendix A 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 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:

- Maintain housing and 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:

- Adherence to prescribed medication;

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

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

Participating County Implementation and Reporting Status

As Shown in Table 1, all 19 counties that have Board of Supervisors approval to operate an AOT program submitted a report to DHCS. Six programs did not serve court-ordered individuals or are in the early stages of implementation; however, information was provided on their programs' progress.

Table 1. Participating County Implementation and 2018-2019 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	X	
Mendocino	X	X	X
Nevada	X	X	X
Orange	X	X	X
Placer	X	X	X
San Diego	X	X	X
San Francisco	X	X	X
San Luis Obispo	X	X	
San Mateo	X	X	X
Santa Barbara	X	X	X
Shasta	X	X	
Stanislaus	X	X	
Ventura	X	X	X
Yolo	X	X	X

Data Collection and Report 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 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 and distinct AOT population reported, 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[11] and procedures to appropriately and accurately aggregate data, as necessary. Therefore, data reported is in aggregate numbers. DHCS aggregates' are dependent upon total participants experiencing each data

[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.
[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 Sections 1798.3, et. seq.
[11] The DHCS Data De-identification Guidelines (DDG) v2.0 is based on the CHHS DDG, which is focused on the assessment of aggregate or summary data for purposes of de-identification and public release. For additional information and to view DDG, see the Public Reporting Guidelines on DHCS' webpage.

element. Overall totals vary.

Reporting Period May 1, 2018 – April 30, 2019

914 individuals were referred to AOT and served during this reporting period. 686 participants 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 outreach and engagement. The remaining 228 individuals entered AOT as a result of court orders or settlements. Statewide outcomes to evaluate program effectiveness are organized by the required data elements, with highlights of each program listed first.

County Highlights

Alameda County began with a five-person AOT pilot program in 2015, then fully implemented the program the following year. In 2018, 93 percent of their clients engaged in voluntary services or were found ineligible after participation with an In Home Outreach Team. Additionally, every client who continued in AOT past the initial 6 month court order, did so through a voluntary settlement agreement.

Contra Costa County is in its third year of providing AOT services and utilizes a Care Team which 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 County reports working collaboratively with both criminal justice and community stakeholders.

Los Angeles County reported serving voluntary clients in a pilot AOT program in 2010, then fully implemented and expanded in 2015. This is their third year reporting on court-involved AOT individuals. The county notes family members of participants express the program has met or exceeded their expectations.

Mendocino County began an AOT pilot program in 2015. In 2018, their program was fully implemented and began serving court-involved individuals. AOT services are provided by the Redwood Quality Management Company. The program has been recognized by the community for its success in participants' overall improvement.

Nevada County has provided AOT services through Turning Point Providence Center since 2008. As a result of Laura's Law, the county reports experiencing less conservatorships; and fewer number of days homeless, incarcerated, and hospitalized. Additionally, the program has had a positive impact in reducing mental health stigma within their community since implementation.

Orange County began their program in 2014 through an AOT-specific FSP. In 2017, the program moved into a building located directly across from the courthouse to increase accessibility for clients attending court hearings. In 2018, the program partnered with Genoa Healthcare to have an on-site pharmacy and has seen a significant increase in the number of clients filling their prescriptions. Additionally, the program's prescribers and nurses spend about 50 percent of their time providing services in the field which helps to build a relationship with clients and increase

adherence to medications.

Placer County is in its fifth year of implementation and have continuously served clients on a voluntary basis. Their AOT program offers a wide variety of social activities and collaborates with community partners to reestablish relationships to assist in reintegration.

San Diego County is in its third year of implementation, however, this is their first year reporting court-involved individuals. The county notes success in leveraging partnerships with court officials, crisis centers, Psychiatric Emergency Response Teams (PERT), and law enforcement in efforts to reduce court petitions. Additionally, the county has experienced a correlation in decreased PERT utilization, hospitalizations, and emergency room visits; and increased outpatient mental health services to include Assertive Community Treatment teams.

San Francisco County began its AOT program November 2015 with a goal to improve the quality of life and prevent decompensation of participants. The county noted, the program has had a significant financial impact in reducing monthly acute psychiatric and jail cost by 83 percent. Additionally, surveyed individuals felt confident in reaching their treatment goals and that AOT could help them live the life they wanted.

San Mateo County implemented its AOT program in July 2016. The County assembled a team consisting of clinical and psychiatric staff, a Deputy Public Guardian and peer support workers who travel throughout the county to evaluate individuals and provide referrals to services, as needed. Additionally, a peer support worker is dedicated to enhance engagement efforts and to provide support to individuals encountering the AOT program.

Santa Barbara County is currently operating an AOT pilot program with ten slots and has engaged over 100 candidates since implementation in 2016. The program has reported success in reducing days hospitalized, building rapport with participants and their families, and supporting incarcerated individuals. Additionally, they have leveraged partnerships with court officials and law enforcement in efforts to reduce court petitions or process.

Ventura County began its AOT program “Assist” in 2016. The program was formally provided through a contractor; however, it is now operated by the Ventura County Behavioral Health Department as of July 2018. Their goal is to reach unserved communities through culturally informed outreach, engagement, and rehabilitation strategies offered by bilingual and bicultural staff.

Yolo County has provided AOT services through Turning Point Community Programs since 2014. The county notes success in the reduction of emergency department visits by participants. Additionally, families have expressed gratitude about their positive experiences of re-engagement and re-connection with their loved ones as a result of the AOT program participation.

Findings

Demographic Information

As Shown in Table 2, the majority of participating individuals were Caucasian males between ages 26 and 49 and received services through a court settlement. In recent years, counties have reported serving more racial and gender diverse populations.

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

DEMOGRAPHIC	TOTAL	% OF TOTAL
COURT PROCESS TYPE		
Court Order	91	40%
Court Settled	137	60%
TOTAL	228	100%
SEX/GENDER		
Female	85	37%
Male	142	63%
TOTAL	227[14]	100%
AGE CATEGORIES		
18-25	18	12%
26-49	107	71%
50+	26	17%
TOTAL	151[14]	100%
RACE/ETHNICITY		
Caucasian/White	91	40%
Black/African American	32	14%
Hispanic/Latino	52	23%
Asian/Pacific Islander	^	^
Other, Multi-race, etc.	^	^
Unknown, Not reported	^	^
TOTAL	227[14]	100%

Homelessness/Housing

Homelessness was modestly reduced, with the majority of clients obtaining and maintaining housing while in the AOT program. Four 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. Five additional counties reported that all participants avoided homelessness, while receiving AOT services. Overall,

[12] ^ Symbol is used for data that has been suppressed to protect individual privacy.
[13] Percentages derived from totals are rounded to the whole numbers throughout the report.
[14] Totals include available data for each element reported by counties. Los Angeles and Placer County did not provide data for one or more elements.

homelessness was reduced by a 30 percent change during AOT, as compared to prior to the program.

Hospitalization

Hospitalizations were reduced by a 33 percent change during AOT, as compared to prior to the program. All counties reported a decrease in the number of days hospitalized, frequency of psychiatric hospitalizations, and/or crisis interventions per individual.

Law Enforcement Contacts

Law enforcement contacts were reduced by a 43 percent change during AOT, as compared to prior to the program. Five counties reported all participants avoided law enforcement contact while receiving services. Four of the six counties that reported incarcerations of participants during AOT, noted reductions in the number of days incarcerated per individual.

Treatment Participation / Engagement

Each county provides data on AOT individuals' adherence to treatment, whether or not they maintained contact with their program, and other indicators of successful engagement, as outlined in statue. The treatment participation and engagement section of this report is comprised of these three required data elements.

Data provided indicated, 62 percent of participants adhered to their treatment plans and 46 percent maintained contact with their program. Two counties reported increased participation as an indicator of successful engagement. Three additional counties noted over 45 percent of ordered participants entered treatment voluntarily when re-petitioned.

Employment

Counties reported that a majority of AOT participants have challenges in obtaining and/or maintaining employment while in treatment. Programs offer and encourage engagement in a variety of employment and educational services. Three counties reported employment for some program participants. Three additional counties noted individuals participating in employment services and/or obtaining stipend volunteer positions.

Victimization

Historically, counties have reported individuals' reluctance to divulge their experiences of being victimized, both prior to and during AOT. Participants who are in the early stages of accepting treatment and recovery, may have refused additional assessments and/or declined to answer victimization questions. All counties continue to note several limitations in fulfilling this required element. The available data suggests that victimization was reduced by an 85 percent change during AOT, as compared to prior to the program.

Violent Behavior

Mirroring victimization, counties report similar limitations in fulfilling this required element. Four counties utilize staff observations and/or statements to report violent behavior towards community providers and/or peers to supplement assessments. The provided data indicated a decrease in violent behavior by a 64 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. Substance use was reduced by a 34 percent change during AOT, as compared to prior to the program. Counties continue to report that many individuals are reluctant or not forthcoming with this information and may underreport use.

Type, Intensity, and Frequency

Counties work with local stakeholders during the initial stages of implementation to determine the type, intensity, and frequency standards of AOT services. In accordance to W&I Code Section 5348, all programs provided client-centered services, which were culturally, gender, and age appropriate. Counties offer a full array of multidisciplinary services with varying frequencies and intensity. Collectively, counties averaged a minimum of two and one half contacts, weekly, with court-involved participants during this reporting period.

Enforcement Mechanisms

Counties define enforcement mechanisms differently but tend to include increased number of update hearings, medication outreach, and/or assessments for potential hospitalizations. Additional status hearings for the purpose of psychiatric evaluation are the most common. Seven of thirteen counties utilize enforcement mechanisms as a component of their program. Of the seven, only two reported use of enforcement mechanisms during this reporting period.

Social Functioning

Ten of thirteen counties reported improved social functioning of 50 percent or more of their participants. The remaining three reported low or no improved social functioning of majority of their participants. Overall, all counties reported individuals' ability to interact with staff, tolerate therapeutic interactions, and/or build peer relationships as a significant outcome.

Independent Living Skills

Ten of thirteen counties reported an improvement in independent living skills for 50 percent or more of their participants. Individuals demonstrated strengthened skills in stress management, food preparation, improved hygiene, and ability to utilize transportation. The remaining three counties reported similar skill levels during AOT, as compared to prior to entering the program.

Service Satisfaction

Ten of 13 counties surveyed AOT participants and their family members to assess satisfaction. Additionally, four of these counties included positive testimonies within their reports. Responses demonstrated overall satisfaction with the AOT program.

Discussion

County data suggests 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. This success was indicated by minimal use of enforcement mechanisms and most participants adhering to treatment. Additionally, several counties noted an increase in crisis interventions, as opposed to psychiatric hospitalizations of participants.

Limitations

There are several noteworthy limitations of DHCS' analysis. The statewide total of court-involved clients remains 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[15] 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 AOT program participants.

Conclusion

The aggregate outcomes of the 228 court-involved individuals, served across 13 counties, indicated success in reducing homelessness, hospitalizations, and incarcerations for the 2018-2019 reporting period.

[15] Statute does not require counties or DHCS to evaluate data on voluntary participants.

Appendix A

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[16], 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 ordered individuals. Patterned after Kendra's Law, California passed Laura's Law, AB 1421(Thomson, Chapter 1017, Statutes of 2002)

47 states and the District of Columbia have assisted outpatient treatment program options (some states refer to it as "outpatient commitment" or "community treatment order") in the United States. Programs are based on the states' needs assessment.

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

Appendix B

Pursuant to W&I Code Section 5346(a), in order to be eligible for AOT, the person must be referred by a qualified requestor and meet the defined criteria:

- The person is 18 years of age or older.
- The person is suffering from a mental illness.
- 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, as demonstrated by at least one of the following:
    - At least two hospitalizations within the last 36 months, including mental health services in a forensic environment.
    - 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.
- 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 W&I Code 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 W&I Code Section 5150.
- It is likely that the person will benefit from assisted outpatient treatment.

A civil process for designated individuals, as defined in W&I Code Section 5346(b), 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 above criteria must be met, voluntary services offered, and options for a court settlement process rather than a hearing that would result in a court order.