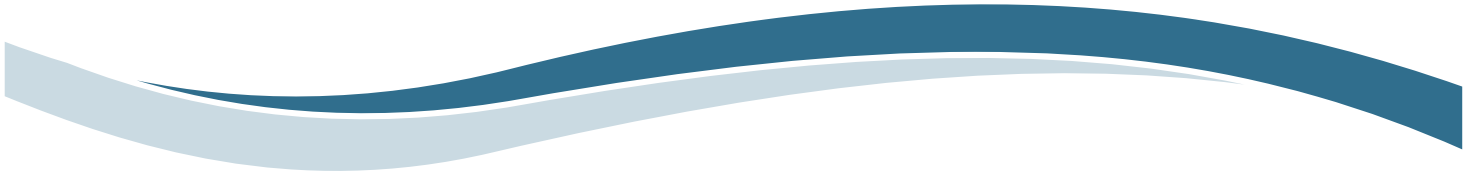
LAURA'S LAW: ASSISTED OUTPATIENT TREATMENT DEMONSTRATION PROJECT ACT OF 2002

For the Reporting Period
July 1, 2022 – June 30, 2023

Department of Health Care Services
Medi-Cal Behavioral Health Policy Division

September 2025



DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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EXECUTIVE SUMMARY

Assembly Bill (AB) 1421 (Thomson, Chapter 1017, Statutes of 2002) established the Assisted Outpatient Treatment (AOT) Demonstration Project Act of 2002 in Welfare and Institutions (W&I) Code sections 5345 – 5349.1, known as Laura's Law. Provisions of Laura's Law require the Department of Health Care Services (DHCS) to collect data outcomes from counties that have implemented[1] the AOT program and produce an annual report on the program's effectiveness which is due to the Legislature annually by May 1. In this report, DHCS is required to evaluate the effectiveness of the program's strategies in reducing the participants'[2] risk for homelessness, hospitalizations, and involvement with local law enforcement.

This report provides statewide programmatic updates and aggregate outcomes[3] for 192 participants from 17 counties that reported court-involved[4] participant data to DHCS for State Fiscal Year (SFY) July 1, 2022 – June 30, 2023. The 17 counties are Alameda, Contra Costa, Humboldt, Kern, Los Angeles, Mendocino, Napa, Nevada, Orange, Sacramento, San Diego, San Francisco, Santa Clara, Stanislaus, Tehama, Tulare, and Ventura.

[1] "Implemented" refers to those counties that have opted-in to AOT and are in various stages of planning and development. Operational counties are those programs that are accepting AOT referrals and provided services during the reporting SFY.
[2] "Participant" refers to an individual who is enrolled in the AOT program.
[3] "Aggregate outcomes" include available data for each element reported by counties.
[4] "Court-involved" refers to the participants who received services through a court petition. Petitioned individuals may waive their right to an AOT hearing that would result in a court-order and instead receive services through a court-settlement.

KEY HIGHLIGHTS

The AOT program showed high voluntary participation – 82 percent[5] of eligible participants responded to the initial invitation for voluntary services and did not require a court petition or process, which is a 2 percent increase from the previous SFY. Aggregate outcomes indicated a positive impact of the primary objectives mandated by the statute governing AOT – homelessness, hospitalizations, and contact with law enforcement. Please reference Appendix C for outcome definitions.

Key Outcomes

- Homelessness decreased by 29 percent.
- Hospitalization decreased by 43 percent.
- Contact with law enforcement decreased by 37 percent.
- Thirty-six percent of participants were able to secure employment or participated in employment and/or educational services.
- Victimization decreased by 68 percent.
- Violent behavior decreased by 52 percent.
- Substance use[6] decreased by 24 percent.
- Counties that provided data on social functioning reported improvements by 44 percent among participants at the time of court discharge.

[5] Percentages are rounded to the closest whole number throughout the report.
[6] The terms "substance use" and "substance use disorder" are clinical terminology preferred over "substance abuse," and are consistent with the current edition of the Diagnostic and Statistical Manual of Mental Disorders, medical societies, professional organizations, recovery advocates, and federal guidance regarding the use of non-stigmatizing, person-centered language.

BACKGROUND

AB 1421 (Thomson, Chapter 1017, Statutes of 2002) established the AOT Demonstration Project Act of 2002, known as Laura's Law. AOT provides 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 a diagnosed 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 information on the AOT 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 was incorporated into DHCS' county mental health performance contracts[7] with the enactment of Senate Bill (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 allowed counties to elect to provide AOT services; however, it did not appropriate 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 the use of Mental Health Services Act (MHSA)[8] funds for AOT services, as described in W&I Code sections 5347 and 5348. 19 counties implemented AOT following the enactment of SB 585. The sunset date was then extended until January 1, 2022, with the enactment of AB 59 (Waldron, Chapter 251, Statutes of 2016).

AB 1976 (Eggman, Chapter 140, Statutes of 2020) required all California counties to offer AOT services, either independently or in a partnership with neighboring counties, unless the county elects to opt out in specified ways. AB 1976 repealed the sunset date of Laura's Law, extending the program indefinitely. Additionally, AB 1976 added a superior

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

[8] The MHSA was passed by California voters in 2004 and was funded by a one percent income tax on personal income in excess of $1 million per year. It was designed to expand and transform California's behavioral health system to better serve individuals with, and at risk of, significant mental health needs, and their families. In 2025, the Behavioral Health Services Act (BHSA) is replacing MHSA.

court judge as an eligible petitioner for AOT services to be filed for a person who appears before the judge.

SB 507 (Eggman, Chapter 426, Statutes of 2021) broadened the criteria to permit AOT for a person who needs such services, without also requiring that the person's condition be substantially deteriorating. This bill additionally required the examining mental health professional, in their affidavit to the court, to determine if the subject of the AOT petition has the capacity to give informed consent regarding psychotropic medication.

SB 1035 (Eggman, Chapter 828, Statutes of 2022) authorized the court to conduct status hearings with the person and the treatment team to receive information regarding progress related to the categories of treatment listed in the treatment plan and authorized the court to inquire about medication adherence. Additionally, this bill required the director of the outpatient treatment program to also report to the court on adherence to prescribed medication when making the affidavit affirming that the person who is the subject of the order continues to meet the criteria for AOT. See Appendix A: History of Involuntary Treatment in California and the Development of Laura's Law for more information on the development of AOT in California.

INTRODUCTION

DHCS is required to report to the Legislature on the effectiveness of AOT programs annually by May 1. Pursuant to W&I Code section 5348, the 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.

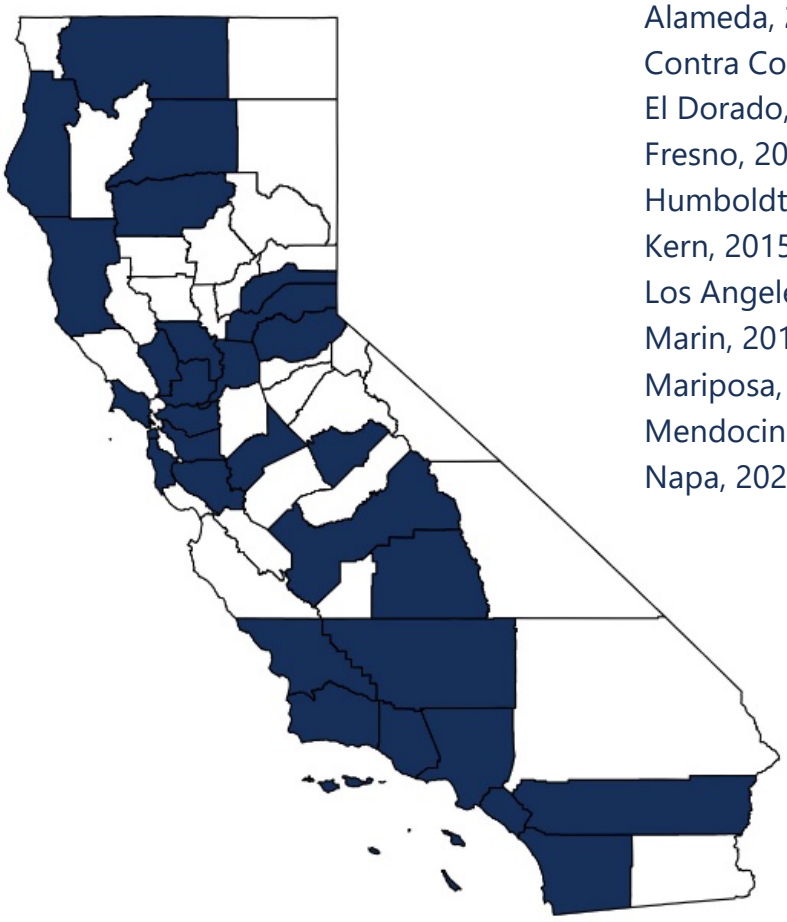
To the extent that data is provided by participating counties, DHCS must also report on the following:

- adherence to prescribed treatment;
- 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;
- enforcement mechanisms;
- level of social functioning;
- independent living skills; and
- satisfaction with program services.

AOT IMPLEMENTATION AND OPERATIONAL STATUS[9]

32 of the 58 counties have implemented AOT services during the SFY July 1, 2022 – June 30, 2023. Of those, 30 counties were operational[10] and have AOT services available during the reporting period as shown in Figure 1.

Figure 1. Counties and Operational Year



Alameda, 2016
Contra Costa, 2016
El Dorado, 2020
Fresno, 2022
Humboldt, 2022
Kern, 2015
Los Angeles, 2015
Marin, 2018
Mariposa, 2021
Mendocino, 2014
Napa, 2021
Nevada, 2008
Orange, 2014
Placer, 2008
Riverside, 2021
Sacramento, 2023
San Diego, 2016
San Francisco, 2015
San Luis Obispo, 2016
San Mateo, 2016
Santa Barbara, 2017
Santa Clara, 2022
Shasta, 2022
Siskiyou, 2020
Solano, 2019
Stanislaus, 2018
Tehama, 2022
Tulare, 2021
Ventura, 2017
Yolo, 2013

[9] Prior reports reflected the county implementation and operational status at the time of the AOT Outcome Evaluation submission.
[10] Fresno, San Luis Obispo, Siskiyou, and Yolo are operational, but no individuals were enrolled in AOT services during this reporting period.

DATA COLLECTION REPORT AND METHODOLOGY

Most counties have implemented their AOT programs as part of their 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 participants from some or all of the following sources:[11]

- Participant intake information;
- MHSA FSP Outcome Evaluation forms including:
  - 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 a participant 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);[12] 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.

[11] Counties utilize additional tools including, but not limited to, pre-established assessments, surveys, and internal data sources (e.g., billing, staff reports, etc.). Data collected from these sources do not fulfill data requirements for DHCS; additionally, the same data elements are not consistent across counties.

[12] The MORS 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 align evaluations of participant progress with the recovery model. MORS scale is used in the assessment of participants' functioning level in the Social Functioning, Engagement and Independent Living Skills sections.

In 2022, DHCS conducted an annual review of the data collection methodology for the Laura's Law Legislative Report to address continued data limitations (i.e., referral data) and further standardize the data collection process. As a result, DHCS issued Behavioral Health Information Notice: 22-035, which provides guidance on AOT implementation and reporting requirements, including the Data Dictionary and Outcome Evaluation.

Fifteen months following the close of each SFY, DHCS receives AOT data from counties that have an implemented AOT program. DHCS conducts a preliminary review for completeness and accuracy of the data, then DHCS completes its analysis and develops the annual report. Due to the lag associated with receiving, processing, and analyzing AOT data, the annual AOT report is published approximately 22 months following the close of the reporting period covered by the report.

DHCS is committed to complying with federal and state laws pertaining to health information privacy and security[13]. Given the small and distinct AOT population data reported, participants may be identifiable; therefore, to protect participants' health information and privacy rights, some numbers for each of the specified outcomes cannot be publicly reported. For DHCS to satisfy its AOT program evaluation reporting requirement, as well as protect participants' health information, DHCS adopted standards[14] and procedures to appropriately aggregate data, as necessary. DHCS' aggregated data are dependent upon total participants' outcomes. All averages are weighted,[15] and overall totals vary.

[13] 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.

[14] The DHCS Data De-identification Guidelines (DDG) V2.2 is based on the California Health & Human Services Agency 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.

[15] All averages are weighted throughout this report unless otherwise indicated.

FINDINGS FOR SFY JULY 1, 2022 – JUNE 30, 2023

Statewide Findings

In addition to the measures specified in W&I Code section 5348, DHCS requests programmatic information from counties with implemented AOT programs. The following sections provide a comprehensive overview of the strategies employed and data outcomes during the SFY 2022-2023 reporting period. Referrals and Enrollment

Laura's Law authorizes specified persons or entities[16] to request county mental health departments to investigate the appropriateness of filing an AOT petition. During this reporting period, 2,103 individuals were referred to AOT services across 26 of the 30 operational counties[17].

As shown in Table 1 and Chart 1 (below), 1,081 individuals (51 percent) were found eligible for AOT, and 710 individuals (34 percent) were found ineligible. Loss of contact with individuals who are the subject of an AOT petition is often attributed to individuals leaving a county once notified of the investigation. Overall, 229 individuals (11 percent) were unable to be located, and 83 individuals (4 percent) were pending investigation/unknown during this reporting period.

Table 1. Total Referral Eligibility: Count and percentage of referrals by type

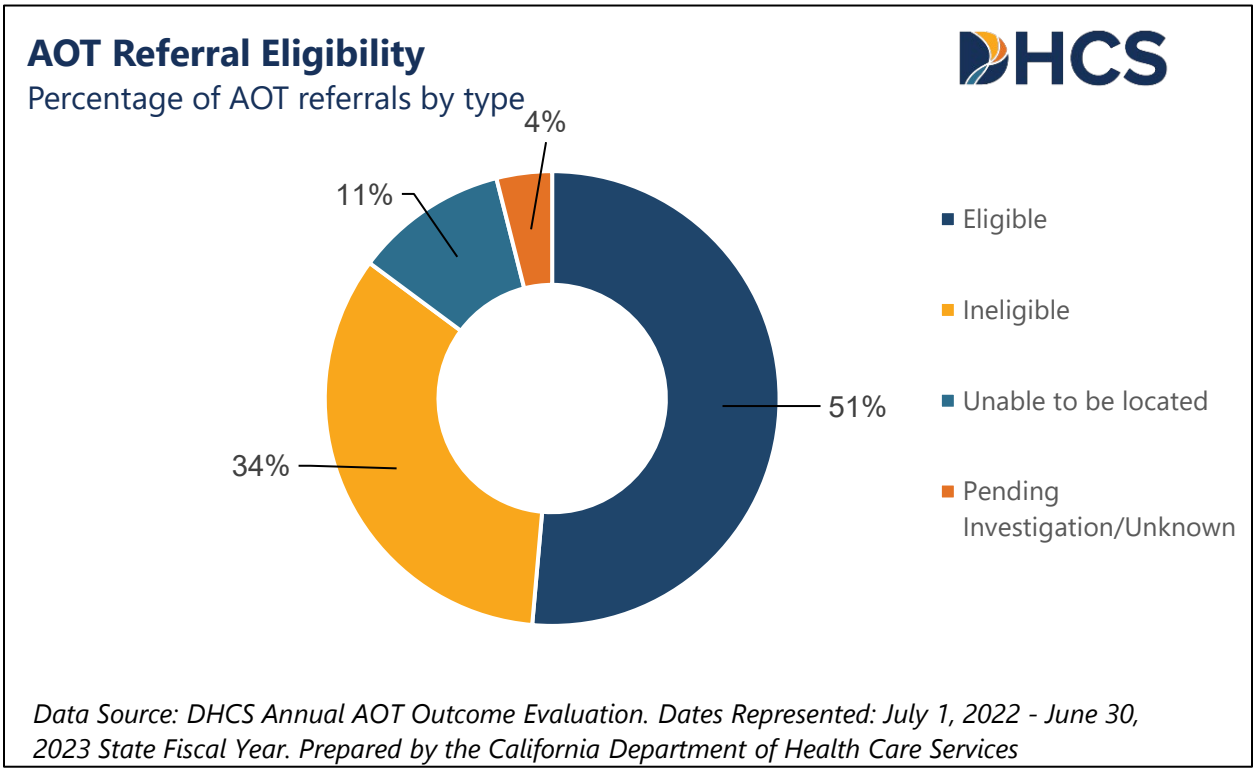
Referrals	Count	Percentage
Eligible	1081	51%
Ineligible	710	34%
Unable to be located	229	11%
Pending Investigation/Unknown[18]	83	4%
Total	2,103	100%

[16] W&I Code section 5346, subd. (b)(2)

[17] Fresno, San Luis Obispo, Siskiyou, and Yolo counties are operational, but no individuals were enrolled in AOT services during this reporting period.

[18] The "Pending Investigation/Unknown" category accounts for referrals that apply for other categories which are not required to be reported by DHCS and could not be separated due to aggregated data.

Chart 1. Overview of Statewide Referral Eligibility



Data Source: DHCS Annual AOT Outcome Evaluation. Dates Represented: July 1, 2022 - June 30, 2023 State Fiscal Year. Prepared by the California Department of Health Care Services

As shown in Table 2 and Chart 2 (below), a total of 343 referred individuals were not enrolled in AOT during this reporting period. Most of these individuals were not enrolled in AOT due to being linked to other Behavioral Health (BH) services, other/ineligible referring party[19], or incarceration. The remaining referred individuals were either hospitalized, out of county, met criteria under the Lanterman-Petris-Short (LPS) Act[20], were referred to a diversion program or the referral was withdrawn.

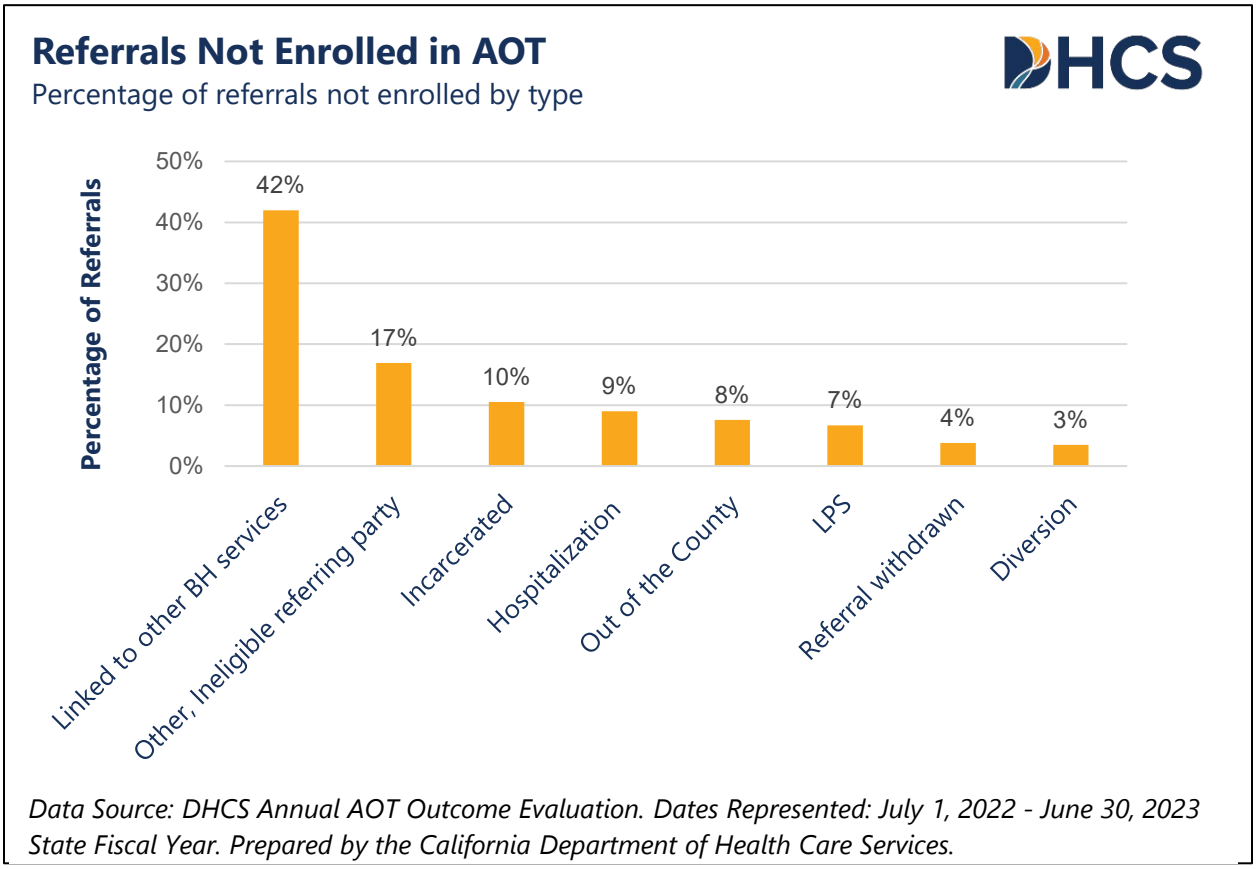
[19] "Other/Ineligible" referring party can include a referral to higher level of care, a Substance Use Disorder program and/or not appearing in court.
[20] For information on the LPS Act, refer to Appendix A.

Table 2. Referrals Not Enrolled: Count and percentage of referrals per category

Referrals not enrolled	Count	Percentage
Linked to other BH services	144	42%
Other, Ineligible referring party[21]	58	17%
Incarcerated	36	10%
Hospitalization	31	9%
Out of County	26	8%
LPS	23	7%
Referral withdrawn	13	4%
Diversion	12	3%
Total	343	100%

[21] "Other" and "Ineligible referring party" are aggregated to protect the confidentiality of individuals in this category.

Chart 2. Overview of Statewide Referrals Not Enrolled



Data Source: DHCS Annual AOT Outcome Evaluation. Dates Represented: July 1, 2022 - June 30, 2023 State Fiscal Year. Prepared by the California Department of Health Care Services.

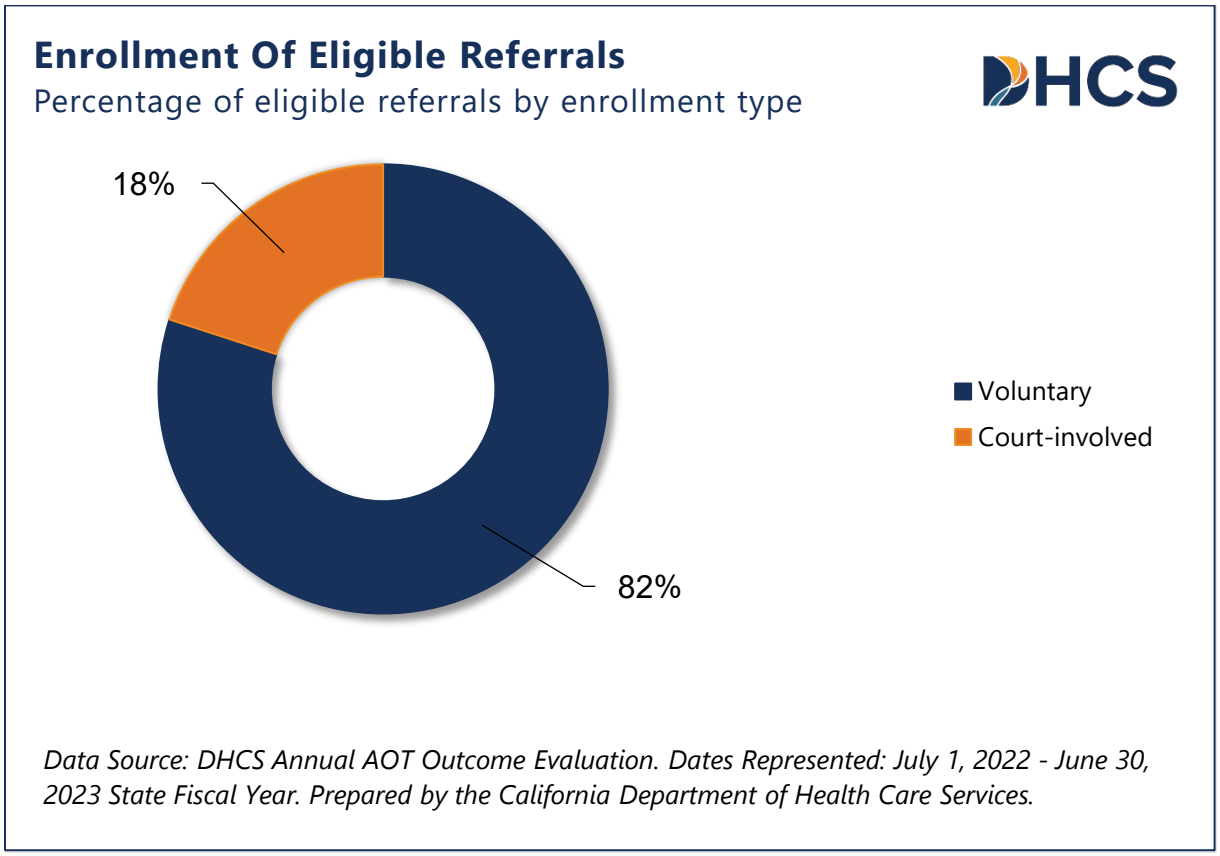
The enrollment[22] data in Table 3 and Chart 3 (below) show that, out of 1,081 eligible referrals, 889 individuals (82 percent) were determined to meet eligibility criteria, accepted voluntary services, and did not require a court petition. Overall, 192 (18 percent) of eligible referrals entered AOT as a result of court orders or settlements.

[22] Seventy-nine participants served in the previous reporting period continued receiving AOT services during the 2022-2023 reporting period. Due to aggregate data collection, DHCS is unable to report the type of enrollment of these individuals.

Table 3. Total Eligible Referrals: Count and percentage of enrollment by type

Enrollment Type	Count	Percentage
Voluntary	889	82%
Court-involved	192	18%
Total	1081	100%

Chart 3. Overview of Statewide Enrollment of Eligible Referrals



Data Source: DHCS Annual AOT Outcome Evaluation. Dates Represented: July 1, 2022 - June 30, 2023 State Fiscal Year. Prepared by the California Department of Health Care Services.

Methods of Outreach and Engagement

Counties indicated that initial outreach is a critical component to locate referred individuals, which is often conducted in collaboration with community partners such as law enforcement, family members, and care providers. Once located, outreach teams promptly triage referred individuals to determine needs, deliver in-field services, and provide connections to appropriate resources. Counties prioritize building rapport with

potential participants to encourage voluntary participation, including outreach teams meeting in a location where the individual feels most comfortable to establish trust. The average duration of county outreach and engagement efforts prior to filing an AOT petition was 52 days with at least 16 contact attempts via phone, email, and/or in-person during this reporting period.

County engagement efforts extend beyond referring individuals and enrolling AOT participants. For example, Nevada County reported that participants improved relationships with family members, obtained and maintained housing, abstained from substance use for a period of time, obtained employment, and increased their social networks. Mendocino County reported that participants were able to maintain their housing requirements by volunteering in the community and participating in groups that help support their mental health. Santa Clara County indicated that participants were able to accept housing as part of their program.

Partnerships and Services

Counties have established and continue to foster partnerships with local organizations to provide whole-person care through a robust array of services. 13 counties reported assisting participants with obtaining financial benefits, such as Social Security Income, Social Security Disability Insurance, and food assistance. 11 counties assisted participants in obtaining vital records or documentation (e.g., identification, birth certificate, social security card). Table 4 (below) displays the number of counties that provided connections to community-based organizations by service type.

Table 4. Community-Based Services[23]

Community-Based Services		
Service Type	Number of Counties	Percentage
Substance use disorder treatment	25	83%
Education services	23	77%
Employment services	23	77%
Housing support	22	73%
Transportation services	20	67%
Benefit acquisition	20	67%
Case management	19	63%
Legal services	19	63%
Crisis intervention	18	60%
Outreach support	17	57%
Medication management	16	53%
Peer support	16	53%
Life skills support	16	53%
Individual/group counseling	16	53%
Rehabilitation	15	50%
Family/Relationship services	12	40%
Diversion	12	40%
Restorative justice	11	37%

Service Satisfaction

Pursuant to W&I Code section 5348(d)(14), DHCS is required to report service satisfaction of participants and/or their families based on available county data. Seven counties reported either not having developed a system to gather service satisfaction or

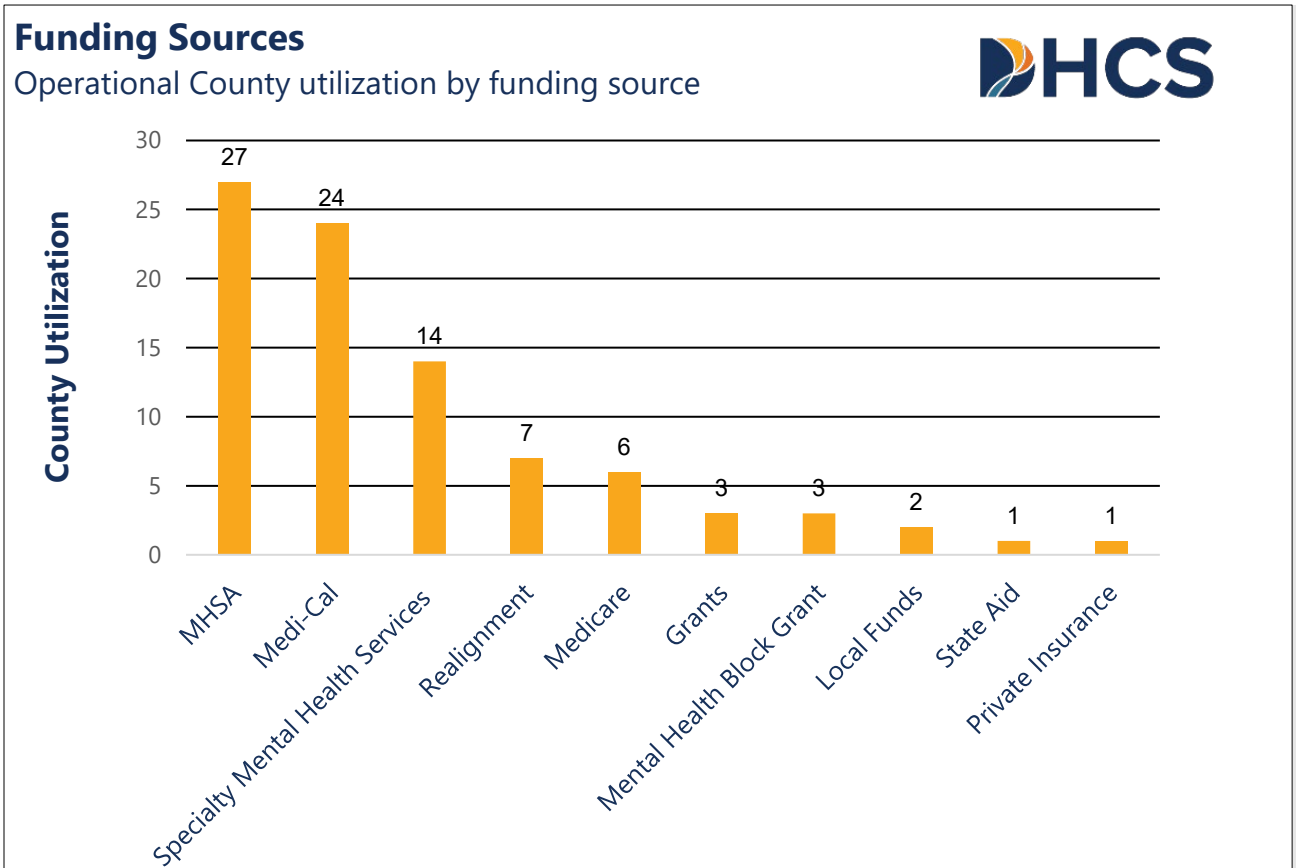
[23] Percentages are derived from 28 operational counties.

participants chose not to complete the service satisfaction survey during the reporting period. DHCS continues to encourage counties to develop and issue consistent satisfaction surveys to program participants and family members to solicit feedback and make program improvements.

Funding Sources

Most counties rely on multiple funding sources to support their AOT programs, with MHSA and Medi-Cal being the most utilized. See chart 4 (below) for an overview of the various funding sources utilized amongst the 30 operational counties.

Chart 4. Overview of Funding Sources



Data Source: DHCS Annual AOT Outcome Evaluation. Dates Represented: July 1, 2022 - June 30, 2023 State Fiscal Year. Prepared by the California Department of Health Care Services.

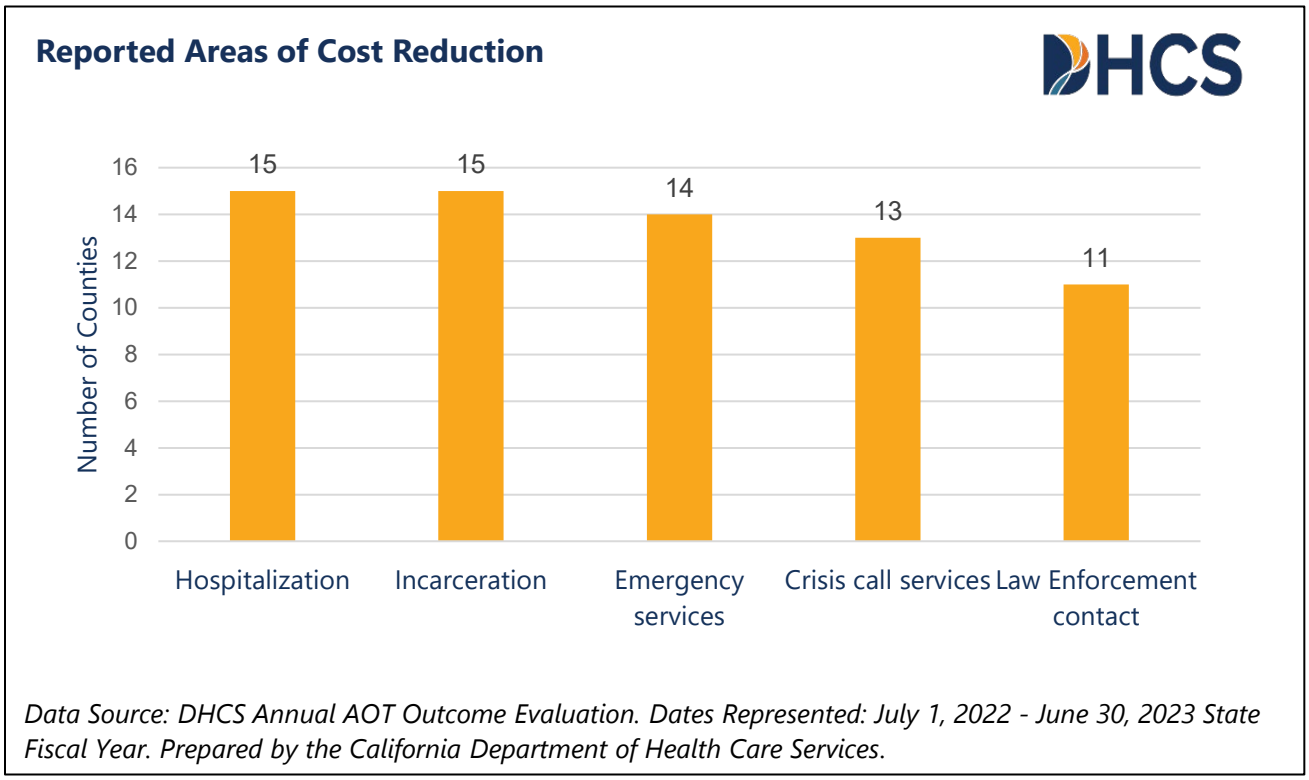
Areas of Significant Cost Reduction

Counties make financial investments to address the comprehensive needs of the AOT population, and these investments have resulted in significant cost savings for some

counties. 15 counties reported that these savings were linked to reductions in hospitalizations, incarceration, emergency services, crisis call services and law enforcement contact. See Chart 5 (below) for an overview of the reported areas of cost reduction. Overall, counties reported hospitalization and incarceration as the highest areas of cost reduction.

Counties also reported utilizing various intervention methods to reduce costs, including crisis call-in lines and mobile crisis teams. Additionally, counties offered voluntary support to crisis stabilization units, safety planning with families and coordination with other county crisis teams.

Chart 5. Overview of Areas of Cost Reduction



Data Source: DHCS Annual AOT Outcome Evaluation. Dates Represented: July 1, 2022 - June 30, 2023 State Fiscal Year. Prepared by the California Department of Health Care Services.

COVID-19 Update

To capture the impacts of the COVID-19 public health emergency on AOT programs, DHCS included evaluation questions related to COVID-19 vaccinations, service delivery modifications, and housing programs.

The federal COVID-19 public health emergency ended on May 11, 2023, which occurred during this reporting period. During this SFY, counties indicated their ongoing utilization of telehealth as an option to provide AOT services and engagement with participants.

22 counties made COVID-19 vaccinations accessible to AOT participants. Counties reported that COVID-19 vaccines were mostly accessible through vaccination clinics at the Public Health Department, case management services (e.g. transportation, vaccine appointment assistance), and community-based vaccine locations.

Contra Costa, Los Angeles, Mendocino, Orange, San Diego, and Ventura counties reported that the court process was held through a virtual format for participants which proved to be beneficial. Alameda County coordinated with Project Roomkey[24] or Homekey[25] to provide shelter to some AOT participants. These efforts of the AOT programs show the counties' commitment to ensuring continued service accessibility and supporting participants during the COVID-19 public health emergency.

[24] Project Roomkey was established as part of the state response to COVID-19 to provide non-congregate shelter options for people experiencing homelessness. For more information on Project Roomkey, visit https://www.cdss.ca.gov/inforesources/cdss-programs/housing-programs/project-roomkey.

[25] Homekey continues a statewide effort to sustain and rapidly expand housing for persons experiencing homelessness or at risk of homelessness. For more information on Homekey, visit https://www.hcd.ca.gov/grants-and-funding/homekey.

Court-Involved Findings

DHCS collects specified data to evaluate the effectiveness of the strategies employed by each program operated for court-involved participants, [26] as outlined in W&I Code section 5348(d). "Court-involved" refers to the participants who received services through a court petition. Petitioned individuals may waive their right to an AOT hearing that would result in a court-order and instead receive services through a court-settlement. The following information is organized by the outcome measures of the required data elements, with court-involved participant enrollment information presented first.

Court-Involved Participant Enrollment

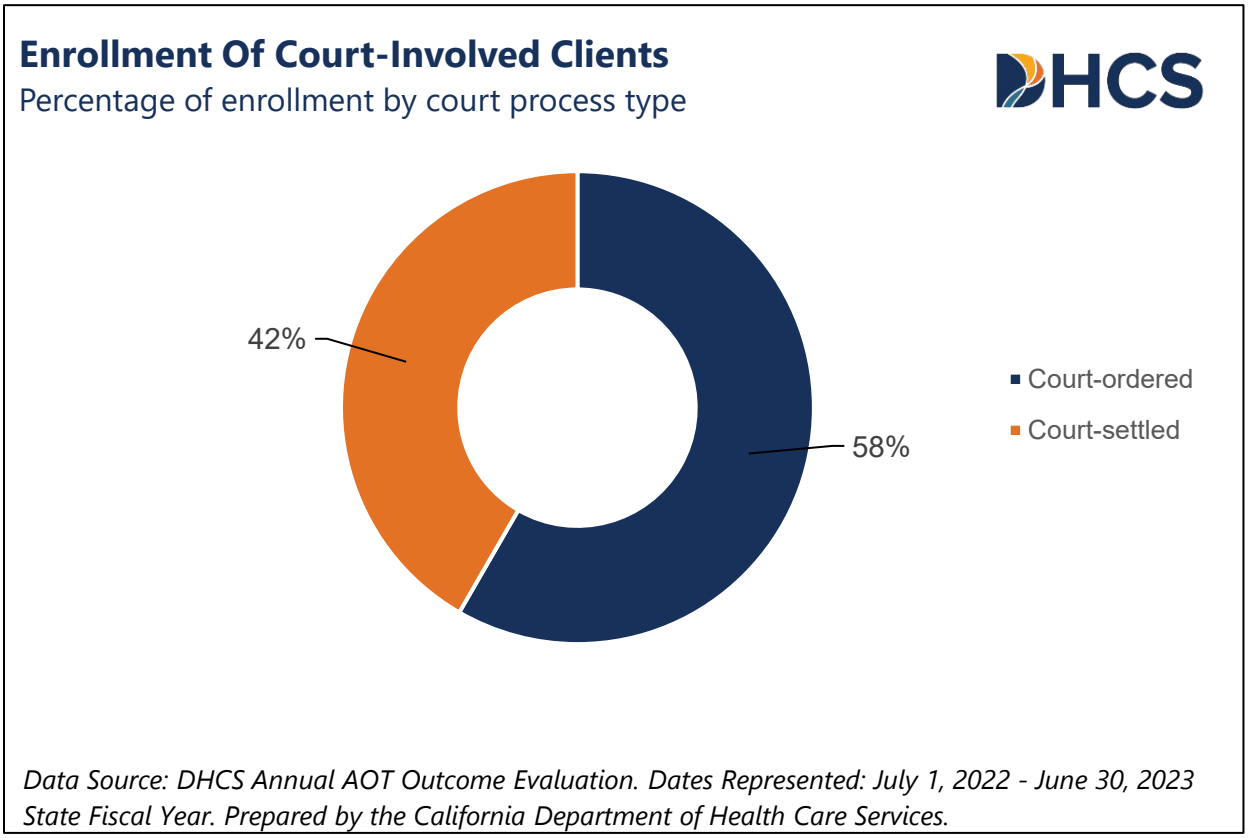
A total of 192 participants were enrolled through a court process within the following 17 counties: Alameda, Contra Costa, Humboldt, Kern, Los Angeles, Mendocino, Napa, Nevada, Orange, Sacramento, San Diego, San Francisco, Santa Clara, Stanislaus, Tehama, Tulare, and Ventura. See Chart 5 (below), for an overview of court process enrollment by type.

Table 5. Enrollment: Total count and percentage by court process type

Court Process Type	Count	Percentage
Court-ordered	112	58%
Court-settled	80	42%
Total	192	100%

[26] Statute does not require counties or DHCS to report data on voluntary participants.

Chart 6. Overview of Court-Involved Enrollment



Data Source: DHCS Annual AOT Outcome Evaluation. Dates Represented: July 1, 2022 - June 30, 2023 State Fiscal Year. Prepared by the California Department of Health Care Services.

Demographic Information of Court-Involved Participants

DHCS collects demographic information from counties with court-involved participants which includes sex/gender, age, and race/ethnicity. See Chart 4 (below), for an overview of collected aggregate statistical demographic data.

Table 6. Participant Demographics of Court-Involved Participants[27]

Participant Demographics	Total	Percentage
Sex/Gender		
Male	126	66%
Female	53	28%
Other, or Unknown/Not Reported[28]	13	6%
Total	192	100%
Age Categories		
18-25	24	13%
26-49	132	69%
50+	24	13%
Unknown/Not Reported	12	5%
Total	192	100%
Race and Ethnicity		
White or Caucasian	57	30%
Black or African American	30	16%
Hispanic or Latino	52	27%
Asian or Asian American	25	12%
Multi-race, or Unknown/Not Reported[29]	28	15%
Total	192	100%

[27] Percentages are derived from 192 court-involved participants.
[28] "Other" and "Unknown/Not Reported" can include transgender or non-binary individuals and are aggregated to protect the confidentiality of participants in this category.
[29] "Multi-race" and "Unknown/Not Reported" can include Native Hawaiian or other Pacific Islander ethnicities of individuals or selection of another race/two or more races and are aggregated to protect the confidentiality of participants in this category.

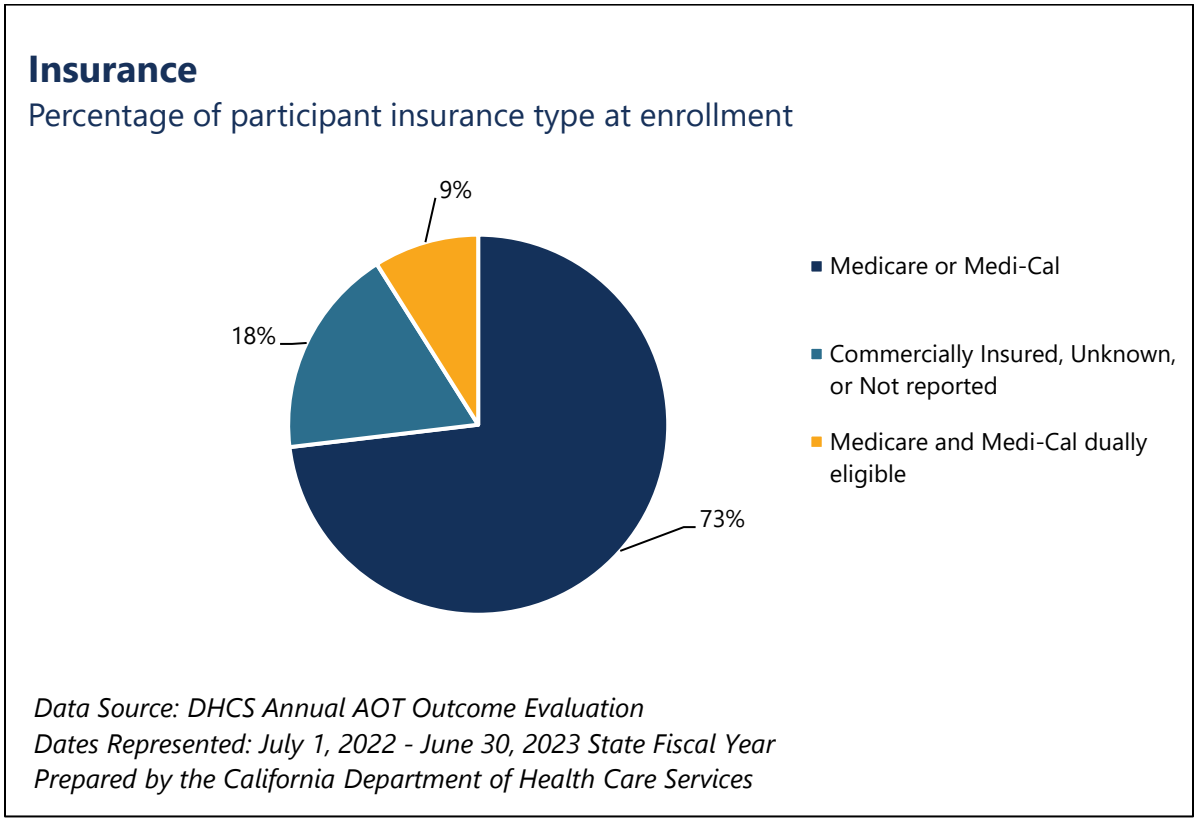
Insurance Type

Court-involved counties report on the types of insurance coverage participants utilized while receiving AOT services. See Chart 7, for an overview of insurance type during AOT enrollment.

Table 7. Enrolled Participants: Count and percentage by Insurance Type

Insurance Type	Count	Percentage
Medicare or Medi-Cal only	141	73%
Commercially Insured, Unknown, or Not reported	33	18%
Medicare and Medi-Cal dually eligible	18	9%
Total	192	100%

Chart 7. Demographics - Insurance Type



AOT Criteria for Eligibility

AOT petitions must include facts to establish that an individual meets the criteria. County clinicians evaluate referred individuals based on self-reported information, including legal history, previous services offered and/or provided, and clinical symptomology.

Once these criteria are met, ongoing monitoring is essential to ensure continued eligibility. Pursuant to W&I Code section 5346(h), every 60 days counties are required to file an affidavit with the court to affirm participants continue to meet the criteria. Table 8 (below) provides an overview of some of the criteria met by court-involved participants. See Appendix B for information on all AOT criteria.

Table 8. Demographics - Percentage of Participants that Met AOT Criteria[30]

Demographics - Percentage of Participants that Met AOT Criteria	
In view of treatment history and current behavior, there has been a clinical determination that participants:	
90%	Are unlikely to survive safely in the community without supervision, and the person's condition is substantially deteriorating
61%	Are in need of AOT in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or to others
Mental illness has, at least twice within the last 36 months, been a substantial factor in:	
69%	Necessitating hospitalization
36%	Receiving services in a forensic or other mental health unit of a correctional facility
Mental illness has, within the last 48 months:	
66%	Resulted in one or more acts of serious and violent behavior toward themselves or another, or threats, or attempts to cause serious physical harm to themselves or another
While enrolled in AOT, were determined to need a higher level of care:	
12%	Resulted in Lanterman-Petris-Short Conservatorship placement

Outcomes

Each county reports pre-enrollment[31], during enrollment, and discharge data for all court-involved participants, as available. These measures are used to evaluate and

[30] Data contains duplication as participants may meet one or more of these categories.
[31] Pre-enrollment refers to data on participant activity or history prior to entering the AOT program. These data are captured up to 12 months prior to participants entering the program.

compare statewide outcomes of the following data elements over the course of the reporting period.

Homelessness/Housing

Fifty-seven percent of participants were housed prior to AOT enrollment. Six counties reported participants successfully obtained housing through the AOT program. 70 percent of participants maintained housing during AOT enrollment. Overall, the number of participants experiencing homelessness was reduced by 29 percent during AOT enrollment, as compared to before program participation.

Hospitalization

Hospitalizations were reduced by 43 percent during AOT enrollment, as compared to before program participation. 11 counties reported the use of crisis interventions to avoid hospitalizations through mobile crisis teams. 10 counties reported a decrease in frequency of hospitalization during AOT enrollment. Additionally, counties provided crisis stabilization voluntary support, coordination with other county crisis teams, and onsite supportive helping staff.

Law Enforcement Contacts

Law enforcement contacts were reduced by 37 percent during AOT enrollment, as compared to before program participation. Mendocino, San Diego, Tehama, and Tulare reported over 50 percent reduction in law enforcement contacts among enrolled participants. Collectively, the days of incarceration or jail were reduced by 314 days in the five counties that provided this data.

Treatment Participation/Engagement

Each county provided data on participants' adherence to treatment, which is when a participant follows a formal authorized treatment plan, as well as other indicators of successful engagement, as outlined in statute. The treatment participation and engagement section of this report is comprised of these three required data elements.

Data indicated that 65 percent of court-involved participants adhered to their treatment plans, and 55 percent maintained contact with their program. 34 percent of court-ordered participants were reported to have entered treatment voluntarily when re-petitioned, and 39 percent completed court-mandated treatment. 14 counties reported the following indicators of successful engagement: probation/parole compliance,

substance use treatment completion, participation in treatment, child protective services/child welfare compliance, and established supportive relationships with providers. Mendocino, Nevada, and Santa Clara counties indicated that participants were able to accept and maintain housing while improving family and social relationships.

Employment and Education

Counties reported that a majority of AOT court-involved participants had challenges in obtaining and/or maintaining employment while in treatment. Six counties reported that court-involved participants engaged in vocational and/or employment services during their AOT enrollment. Several counties offered and encouraged engagement in a variety of employment services, including, but not limited to, vocational training, community volunteer work, and resume writing classes. Data gathered demonstrates that there was a 75 percent increase in gainful employment for participants during AOT enrollment, as compared to before program participation.

Data from counties indicated that there was a 50 percent increase in participation in education-related services during AOT enrollment as compared to prior to enrollment. Orange County reported that they worked closely with their FSP provider's vocational/educational specialist on preparing for interviews, creating resumes, obtaining clothes for interviews, and actively searching for employment and volunteer work.

Victimization

Historically, counties have reported at participants' discretion as it relates to victimization, both prior to and during AOT enrollment. Participants, especially those in the early stages of accepting treatment and recovery, may refuse additional assessments and/or decline to answer questions regarding physical, verbal, and/or sexual aggression. All counties have noted several limitations in fulfilling this required element. Nine counties reported that victimization was reduced by 68 percent during AOT enrollment, as compared to before program participation. The following counties reported a significant decrease in victimization from pre-enrollment to during enrollment: Alameda, Contra Costa, Mendocino, Nevada, and Santa Clara.

Violent Behavior

Similar to victimization, counties report limitations in reporting violent behavior. Many counties utilize staff observations and/or statements to report violent behavior towards

community providers and/or peers to supplement assessments. Overall, 15 counties provided data indicating a decrease in violent behavior by 52 percent during AOT enrollment, as compared to before program participation with the following counties demonstrating a significant decrease: Alameda, Los Angeles, Orange, and San Diego.

Substance Use

The majority of participants in AOT are living with co-occurring diagnoses, including mental illness with a substance use disorder (SUD). Eight counties reported successful SUD treatment completion of enrolled participants. 12 counties regularly screen for substance use, which can assist in identifying when participants may need additional support to progress towards treatment goals. Overall, substance use was reduced by 24 percent for court-involved participants during AOT enrollment, as compared to before program participation.

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 treatment services. In accordance with W&I Code section 5348, programs are required to provide person-centered services that are gender, age, and culturally appropriate. Counties offer a full array of multidisciplinary services with varying frequencies and intensity. Collectively, the median number of service contacts with court-involved participants was two per week, for approximately 90 minutes per contact. The average length of time of AOT enrollment was 350 days during this reporting period.

Enforcement Mechanisms

Enforcement mechanisms include methods and/or actions to ensure compliance with treatment by AOT participants. These mechanisms are used to encourage treatment plan compliance which may include, but are not limited to, increased number of update hearings, increased case management, increased intensity of treatment, additional mental health evaluations, and medication outreach/monitoring. 15 of the 17 counties that served court-involved participants reported utilizing enforcement mechanisms[32].

[32] As outlined in W&I Code section 5348(d), counties must provide data on required elements, if available. Enforcement mechanism data were not available for two counties.

Five counties reported using enforcement mechanisms for some participants during AOT enrollment.

Social Functioning

Counties may use assessments and/or collateral reports to determine a participant's social functioning[33]. All 17 counties reported that, compared to the time of enrollment, there was an overall improvement of 50 percent through the initial 180 days of enrollment. At the time of discharge of court-involved participants, counties reported a 44 percent improvement, which demonstrates a slight decrease from the initial 180 days of enrollment.

Independent Living Skills

Independent living skills refer to a participants' ability to manage activities relevant to daily living such as stress management, food preparation, hygiene maintenance, and the ability to utilize transportation. 11 court-involved counties reported that compared to the time of enrollment, 30 percent of court-involved participants demonstrated improvement through the initial 180 days of enrollment, and 27 percent demonstrated an improvement at the time of discharge.

Limitations

The following limitations were identified in DHCS' analysis of the AOT program. First, the statewide total number of court-involved participants remains small; therefore, the outcome improvements cannot be exclusively linked to AOT program services. Additionally, 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. DHCS requests the number of participants served in a previous reporting period; however, data outcomes for these participants remain aggregated with the other court-involved participants.

[33] Social functioning is defined as an individual's interactions and ability to self-manage, without impact from symptoms of diagnoses, within environments including, but not limited to, community, treatment program, social activities, and relationships with support systems. Examples may include the ability to interact positively with staff, participation in extracurricular activities, and building peer relationships.

The AOT program lacks a centralized database to submit the required data, and counties utilize various systems to collect information. The absence of a standardized service satisfaction survey across the counties limits consistent evaluation of participant feedback. However, DHCS continues to conduct an annual evaluation of the collection tools and makes enhancements, where applicable, to further address these limitations.

Discussion

The needs of the vulnerable population eligible for AOT are complex; thus, the strategies employed by counties to support whole-person wellness were uniquely designed to meet the full-spectrum of participants' treatment goals. DHCS' analysis suggests overall improved outcomes for AOT program participants and an increase in voluntary participation.

Counties demonstrated efforts to provide an equity-focused approach to ensure AOT participants received age, gender, and culturally appropriate services. Despite the challenges brought forth by the COVID-19 public health emergency, counties and providers continued delivering services. Throughout AOT programs, BH staff connected participants with access to shelter, employment and educational training, medication, counseling, and additional resources to aid in recovery.

Additionally, county partnerships have been essential in conducting outreach and providing supportive services to AOT participants, including SUD services. In some cases, a participant's substance use may be so severe that it overrides the participant's ability to engage in treatment or is the primary issue leading to impairments in functioning or safety risks. Through collaborative partnerships, counties have made considerable efforts to promote safety and concurrent access to mental health and SUD services to better serve AOT participants.

Conclusion

This report provides a comprehensive overview of the AOT program findings, including program successes, limitations, and challenges, for the SFY 2022-2023 reporting period. Despite the challenges discussed above, the AOT program has effectively addressed participants' needs. The ongoing commitment of the counties to provide integral services through collaborative efforts with community partners and innovative engagement strategies remains crucial to support the stabilization and recovery of the AOT participants. The aggregate outcomes of the 192 court-involved participants indicated positive results in the required outcome measures, including reductions in homelessness, hospitalizations, and involvement with law enforcement.

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

Among significant reforms in mental health care, the LPS Act (SB 677, Short, 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 (i.e., 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 passed Kendra's law[34], after Kendra Webdale was pushed in front of a subway train. A man with a long history of severe mental instability and multiple short 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." New York 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).

Forty-seven states and the District of Columbia have AOT program options (some states refer to it as "outpatient commitment" or "community treatment order"). Programs are based on the state's needs assessment.

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

Appendix B: AOT Criteria

Pursuant to W&I Code section 5346(a), in order to be eligible for AOT, a 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, in view of the person's treatment history and current behavior, at least one of the following is true:
  - The person is unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating.
  - The person is in need of AOT in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or to others.
- The person has a history of lack of compliance with treatment for their 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 themselves or another, or threats, or attempts to cause serious physical harm to themselves 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 their designee, provided that the treatment plan includes all the services described in W&I Code section 5348, and the person continues to fail to engage in treatment.
- Participation in the AOT program would be the least restrictive placement necessary to ensure the person's recovery and stability.
- It is likely that the person will benefit from AOT.

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 there must be an option for a court settlement process rather than a hearing that would result in a court order.

APPENDIX C – GLOSSARY

Adherence to Prescribed Treatment: A participant who correctly follows a formal authorized treatment plan.

Enforcement Mechanisms: Method(s) and/or action(s) implemented to ensure compliance of treatment by AOT participants.

Employment: A participant who is legally employed.

Employment Services: A participant who participates in vocational rehabilitation programs that offer job training.

Frequency of Treatment: The average number of occurrences, periodic or recurrent, of treatment services provided to AOT program recipients in a week (7 days) span. This includes all face-to-face and non-face-to-face treatment provided to AOT participants for the duration of enrollment.

Homelessness: A participant who lacks a fixed, regular, and adequate nighttime residence.

Hospitalization: A participant admitted to a health facility.

Independent Living Skills: A participant's ability to perform activities relevant to daily living.

Intensity of Treatment: The average length of each encounter with an AOT participant. This includes all face-to-face and non-face-to-face treatment provided to an AOT participant for the duration of enrollment.

Law Enforcement Contact: Any interaction with law enforcement that leads to the arrest, citation, and/or booking of the participant.

Maintain Contact with Treatment System: A participant who consistently engages with the treatment system for the duration of receiving AOT services.

Maintained Housing: A participant who did not experience one day (24 hours) of homelessness (as defined above) for the duration of receiving services through the AOT program.

Other Indicators of Successful Engagement: Additional measures, not included in the required elements of W&I Code section 5348(d), that demonstrates program efficacy and/or reduced homelessness, hospitalization, and involvement with local law enforcement by people in the program.

Services Satisfaction: The measure of satisfaction with the AOT program and the services provided to participants and/or family members of participants served.

Social Functioning: A participant's interaction and ability to self-manage, without impact from symptoms of diagnoses, within environments including, but not limited to, community, treatment programs, social activities, and relationships with support systems
Substance Use: A higher degree of use, whereby a participant continues to use alcohol or drugs despite the presence of negative impacts.

Type of Treatment: All services included in a court-mandated treatment plan and/or provided to an AOT participant for the duration of enrollment.

Victimization: The act or process of someone being injured or damaged by another person(s) resulting in physical or psychological harm to the victim.

Violent Behavior: Any display of aggressive, reckless, and dangerous behaviors that have significant potential to result in physical and/or psychological harm.