CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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

For the Reporting Period
July 1, 2019 – June 30, 2020

Department of Health Care Services
Community Services Division

May 2022
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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 – 5349.5, 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 to 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 programs' strategies in reducing the clients'[2] risk for homelessness, hospitalizations, and involvement with local law enforcement.

This report serves as the May 1, 2021 annual report, and provides statewide programmatic updates and aggregate outcomes[3] for 258 individuals from 15 counties that reported court-involved[4] client data to DHCS for State Fiscal Year (SFY) July 1, 2019 - June 30, 2020.

[1] Implemented counties refers to those that have opted-in to AOT, and are in various stages of planning and development. Operational counties are those programs that are operating to provide services.

[2] "Client" refers to an individual who is receiving services from an AOT program, including during initial outreach. This term is used interchangeably with "participant."

[3] Aggregate outcomes include available data for each element reported by counties.

[4] "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 instead receive services through a court settlement.

Key Highlights and Developments for this Reporting Period

The AOT program showed high voluntary participation – 72 percent[5] of eligible individuals responded to the initial invitation for voluntary services, and did not require a court petition or process. Counties attribute this to successful initial outreach and engagement.

Key Highlights:

- ▼ Homelessness decreased by 32 percent.
- ▼ Hospitalization decreased by 40 percent.
- ▼ Contact with law enforcement decreased by 42 percent.
- \+ Thirty percent of individuals were able to secure employment or participated in employment and/or educational services.
- ▼ Victimization decreased by 72 percent.
- ▼ Violent behavior decreased by 63 percent.
- ▼ Substance abuse was reduced by 21 percent.
- \+ Counties that provided data on clients' social functioning and independent living skills reported improvements in these areas.
- \+ Satisfaction surveys indicated both client and family member satisfaction with AOT services.

Important Developments:

1. Newly enacted legislation resulted in statewide expansion of AOT services.
2. Twenty-eight percent of referred individuals who met AOT criteria required court involvement to participate in AOT services.
3. Aggregate outcomes indicated a positive impact on the three outcome elements mandated by the statute governing AOT – homelessness, hospitalizations, and incarcerations.
4. Despite the challenges of the COVID-19 public health emergency, all AOT programs were resourceful in order to maintain treatment services and continue serving clients.

Background

AB 1421 (Thomson, Chapter 1017, Statutes of 2002) established the Assisted Outpatient Treatment 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

[5] Percentages are rounded to the closest whole number throughout the report.

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[6] 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)[7] funds for Laura's Law services, as described in W&I Code Sections 5347 and 5348. Nineteen counties implemented AOT following of the enactment of SB 585. The sunset date was again 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. The bill prohibited a county from reducing existing voluntary mental health programs as a result of the implementation of AOT services. Counties may either offer AOT services independently or choose to partner with neighboring counties. Counties are permitted to opt out from participation through the passage of a resolution adopted by their Board of Supervisors identifying the reasons for opting out. AB 1976 additionally repealed the sunset date of Laura's Law, extending the program indefinitely. As of July 1, 2021, 11 new counties opted to provide AOT services, bringing the total number of AOT opt in counties to 31.

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

[7] The MHSA was passed by California voters in 2004 and is funded by a one percent income tax on personal income in excess of $1 million per year. It is designed to expand and transform California's behavioral health system to better serve individuals with, and at risk of, serious mental health issues, and their families.

SB 507 (Eggman, Chapter 426, Statutes of 2021) expanded the criteria for when AOT services may be court-ordered, to include the requirement that AOT is needed to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or to others, without also requiring that a person's condition be substantially deteriorating. The bill added "eligible conservatees,"[8] as a qualified person to be petitioned for the AOT program. The bill additionally requires the examining mental health professional to determine if the subject of the AOT petition has the capacity to give informed consent regarding psychotropic medication in their affidavit to the court. (See Appendix A 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 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 abuse;
- 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.

[8] Eligible conservatee is a person who is the subject of a pending petition to terminate a conservatorship, and if the petition is granted, would benefit from AOT to reduce the risk of deteriorating mental health while living independently.

Participating County Implementation Status

As shown in Table 1. Participating County Implementation Year and Status31 counties have opted to provide AOT services. Twenty-three counties have operational programs, and of those, 15 served court-involved individuals during the reporting period. Eight counties are in the planning and development stage of implementation.

Table 1. Participating County Implementation Year and Status

County	Implementation Year	Operational During 19-20 SFY	Served Court-Involved
2008			
Nevada	●	●	●
2013			
Yolo	●	●	
2014			
Orange	●	●	●
Placer	●	●	●
2015			
Kern	●	●	●
Los Angeles	●	●	●
Mendocino	●	●	●
San Diego	●	●	●
San Francisco	●	●	●
2016			
Alameda	●	●	●
Contra Costa	●	●	●
San Luis Obispo	●	●	
San Mateo	●	●	●
2017			
El Dorado	●	●	
Santa Barbara	●	●	●
Ventura	●	●	●
2018			
Marin	●	●	●
Shasta	●	●	
2019			
Stanislaus	●	●	●
Solano	●	●	●
2021			
Fresno	●		
Humboldt	●		
Kings	●		
Mariposa	●		
Napa	●		
Riverside	●		
Sacramento	●		
Santa Clara	●		
Siskiyou	●		
Tehama	●		
Tulare	●		

Data Collection and Report 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 clients from some or all of the following sources:[9]

- 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); [10] 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.

DHCS convened an internal workgroup in 2019 to develop the AOT Survey for data collection, define the elements outlined in statute utilizing internal data systems and federal definitions, and standardize the reporting period. All counties reported available data outcomes for the July 1, 2019 - June 30, 2020 SFY using the AOT Data Dictionary and survey tool.

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[9] 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 in these sources do not fulfill data requirements for DHCS; additionally, the same data elements are not consistent across counties.

[10] 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.

Due to the small and distinct AOT population data reported, clients may be identifiable. DHCS is committed to complying with federal and state laws pertaining to health information privacy and security.[11] 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[12] and procedures to appropriately and accurately aggregate data, as necessary. DHCS aggregates' are dependent upon total participants experiencing each data element. Overall totals vary.

[11] Federal laws: Privacy Rule and the Security Rule contained in the Health Insurance Portability and Accountability Act (HIPPA) 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.

[12] The DHCS Data De-identification Guidelines (DDG) v2.0 is based on the California Health & Human Services Agency (CalHHS) 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.

Figure 1. Expanding AOT in California

California Counties with Assisted Outpatient Treatment (AOT) Programs

Counties

- Alameda
- Contra Costa
- El Dorado
- Fresno
- Humboldt
- Kern
- Kings
- Los Angeles
- Marin
- Mariposa
- Mendocino
- Napa
- Nevada
- Orange
- Placer
- Riverside
- Sacramento
- San Diego
- San Francisco
- San Luis Obispo
- San Mateo
- Santa Barbara
- Santa Clara
- Shasta
- Siskiyou
- Solano
- Stanislaus
- Tehama
- Tulare
- Ventura
- Yolo

As a result of newly implemented county AOT programs, AOT services will now be available in over 50 percent of California counties; however, the need for comprehensive mental health services, such as AOT, continues to grow. Additionally, there has been an increase in newly proposed legislation directly and indirectly impacting AOT accessibility and eligibility criteria. DHCS anticipates that AOT programs will experience increased numbers of individuals in need of treatment.

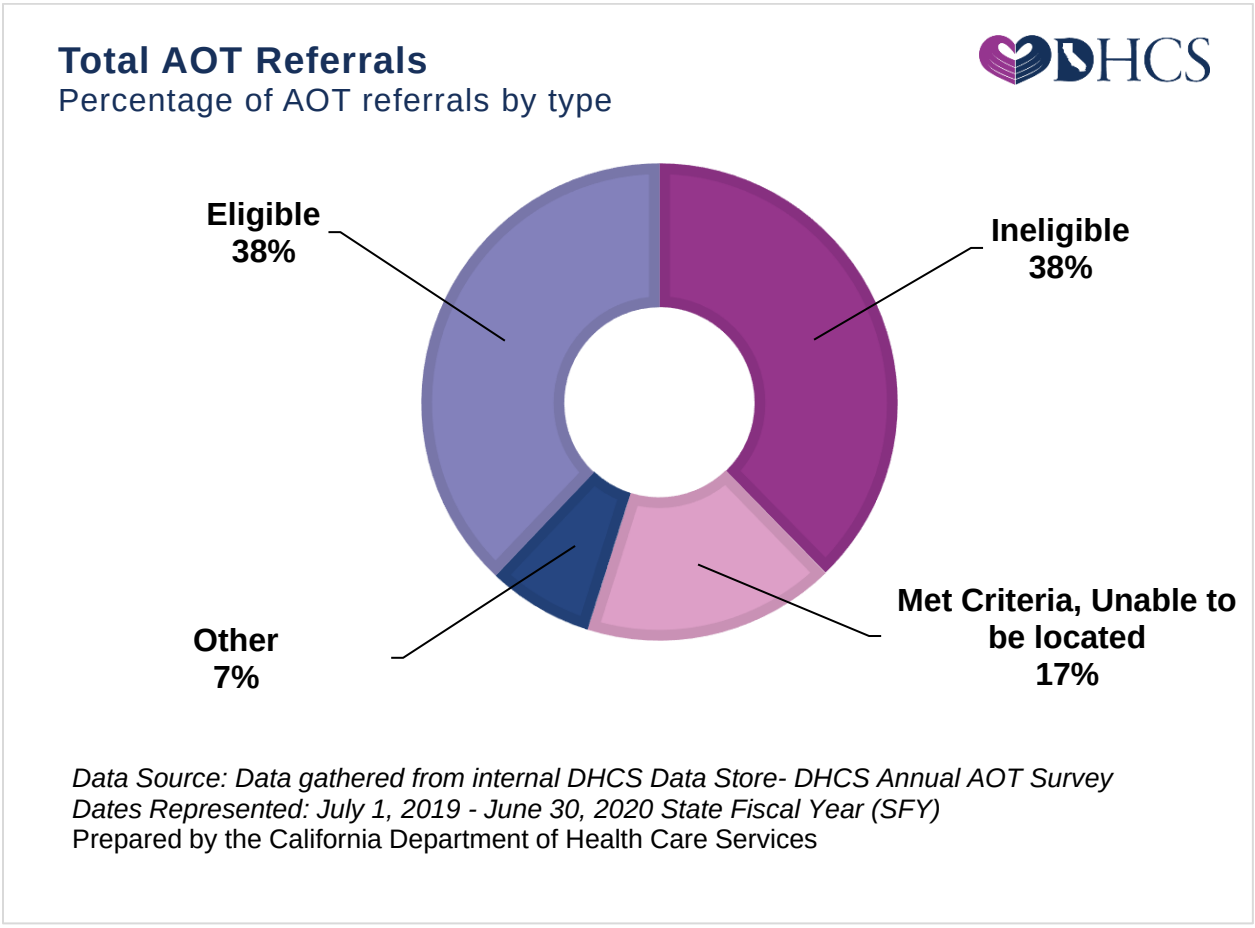
Findings for the July 1, 2019 - June 30, 2020 SFY Reporting Period

Statewide Findings

In SFY 2019-20, 2,420 individuals were referred to AOT during this reporting period across all 23 counties with operational AOT programs. As shown in Chart 1, most counties reported that many referred individuals were deemed ineligible or no longer met AOT criteria after initial contact with outreach teams. Ineligible clients were given the opportunity to access less intensive behavioral health treatment services. Overall, 913 individuals were found to be ineligible. Of the referred individuals who met AOT criteria, 415 were unable to be located.[13] 660 responded to the initial invitation to voluntary services, and did not require a court petition or process; counties attribute this to successful initial outreach and engagement, and 258 individuals entered AOT as a result of court orders or settlements. 174 individuals were either pending investigation at the time of reporting, or were placed into a category not required for reporting by DHCS. (See Appendix B for information on the AOT criteria and referral process.)

[13] Counties often attribute loss of contact with participants to individuals leaving a county once they are notified of investigation. Counties additionally report that some individuals are eventually located and re-engaged for services. These individuals may or may not be included in this report.

Chart 2. Overview of Statewide Referrals for July 1, 2019 - June 30, 2020 SFY[14]



Data Source: Data gathered from internal DHCS Data Store- DHCS Annual AOT Survey
Dates Represented: July 1, 2019 - June 30, 2020 State Fiscal Year (SFY)
Prepared by the California Department of Health Care Services

Table 2. Chart Table-Total AOT Referrals: Count of AOT referrals by type

Referral Type	Count
Ineligible	913
Met Criteria, Unable to be located	415
Other	174
Eligible	918
Total	2,420

[14] DHCS previously reported on the number of referrals that were pending investigation; this category is now reported as "Other" in order to account for referrals that apply for other categories which are not required for reporting by DHCS and could not be separated due to aggregated data.

Chart 3. Total Enrollment of Eligible Referrals for July 1, 2019 - June 30, 2020 SFY

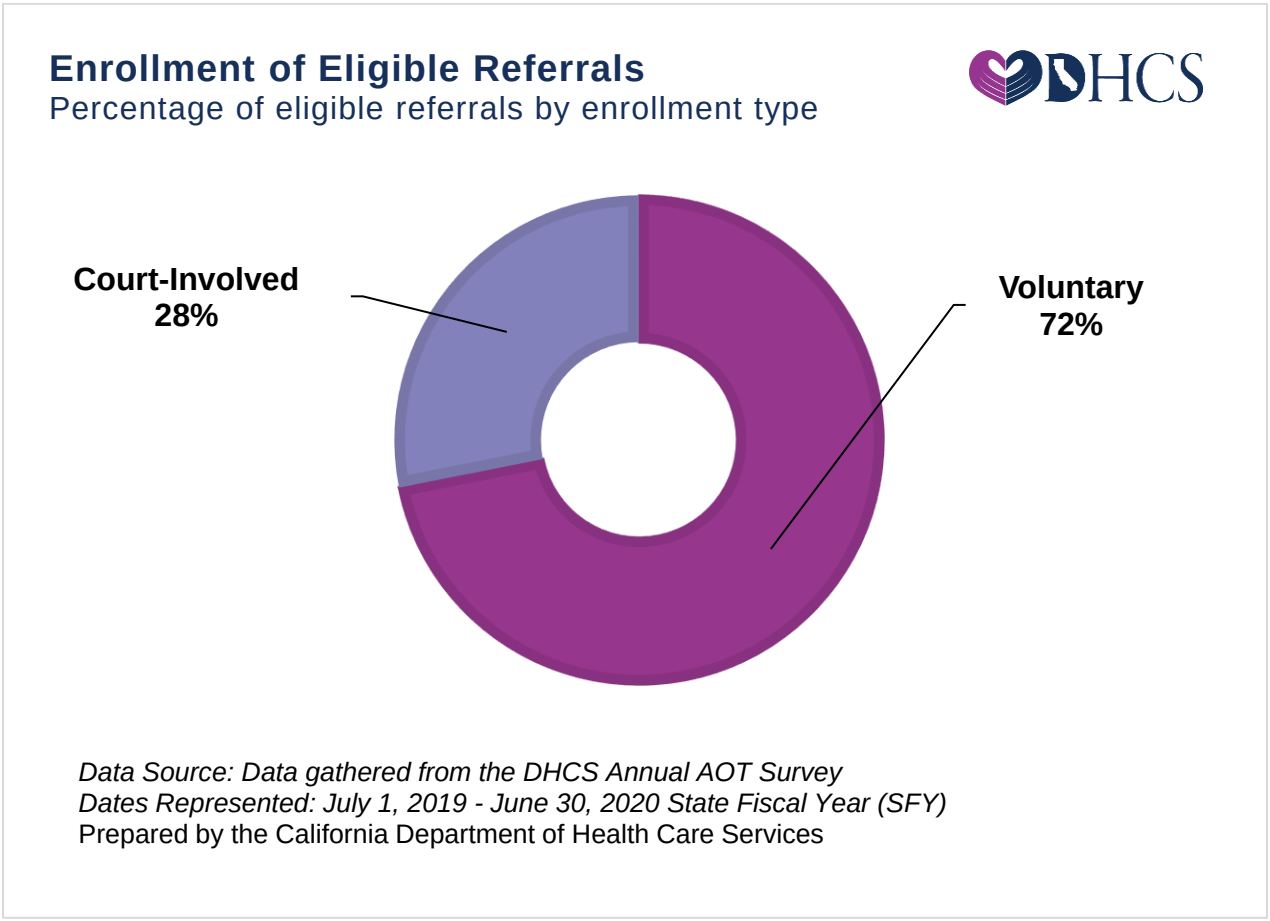


Table 3. Chart Table-Enrollment of Eligible Referrals: Count of eligible referrals by enrollment type

Enrollment Type	Count
Voluntary	660
Court-Involved	258
Total	918

DHCS requests programmatic data from all AOT participating counties using a standardized data collection survey to assess the strategies used in providing AOT services. The following section provides insight on the resourcefulness and dedication of AOT programs.

Methods of Outreach and Engagement

Counties reported a variety of strategies for engaging with referred individuals. All counties applied a comprehensive approach in order to locate clients, triage services to determine individual needs, deliver services in the field, and link clients to appropriate resources.

Many counties described the importance of collaboration with community partners, such as law enforcement and care providers, in order to locate referred individuals. AOT outreach teams make it a priority to meet with clients in locations in which they feel most comfortable. They also work to establish trust in order to encourage voluntary participation in services. Counties have numerous methods for building relationships and establishing rapport with clients. Placer County explains that trained staff tailor their outreach approach to each individual. Ventura County uses a person-centered treatment plan, which provides services that align with individual needs and recovery goals. Some counties reported family engagement to aid in the client's recovery. San Francisco reports the use of flexible funds to engage with individuals over a cup of coffee or a meal. Staff also provide basic necessities as needed, including clothing, food, and toiletries. In Orange County, clinical staff, including prescribers (e.g., nurse practitioners), spend approximately 65 percent of their time engaging clients in the field. Alameda County hosts monthly collaborative meetings for all outreach teams to share best practices and community resources. Anonymous participant testimonials consistently expressed appreciation for the perseverance and innovation of the outreach teams efforts.

Counties have also adopted strategies to provide support and treatment services in the field. Orange County provides on-site phlebotomy services in the treatment provider office, as well as an on-site pharmacy, in an effort to reduce barriers to medication access and support. Contra Costa County uses Harm Reduction and Motivational Interviewing techniques to support those with substance use. Five counties reported providing transportation to outpatient services from hospitals and jails. Additionally, counties have reported assisting clients with locating housing, and accessing benefits, such as Medi-Cal and food assistance. These outreach and engagement efforts help to stabilize clients and encourage their participation in services.

Partnerships

Counties developed partnerships to support AOT with multiple entities, including, but not limited to: housing support agencies, vocational and educational development organizations, substance use treatment providers, food and clothing aid, local police departments, clinics and hospitals. County-contracted behavioral health agencies, case managers, local universities, non-profits, inter-agency collaborative and peer groups

contributed to the robust access to resources for AOT participants.

Counties have created a peer support and mentoring network of all AOT implemented counties to ensure program success both locally and statewide. Los Angeles County conducts quarterly check-in calls with all implemented counties in California for the purpose of feedback and collaboration. Counties are provided with the opportunity to share strategies for success and may request peer county support in the development and expansion of AOT services. Nevada County, which established the first AOT program in California, has been instrumental in assisting new counties with a fundamental framework for AOT program implementation. Counties consistently report that resource and information leveraging with the experienced and established AOT programs helps to navigate challenges that are unique to AOT.

Service Satisfaction

Pursuant to W&I Code Section 5348(d)(14), DHCS is required to report service satisfaction of clients and/or their families based on available county data. DHCS encourages counties to develop and issue consistent satisfaction surveys to program participants and family members to solicit feedback and promote program adaptability. Nine counties provided survey data for this reporting period. Four counties received anonymous surveys for both AOT and Assertive Community Treatment (ACT)[15] services, and thus cannot determine results for individual AOT participants. The remaining counties either did not receive surveys from participants, or reported that satisfaction surveys are currently in development. In lieu of service satisfaction survey data, four counties provided anonymous participant testimonials. Several participants noted they felt supported by staff, and appreciated that staff “didn’t give up on” them. Some participants expressed an improved sense of optimism. Overall, the data available indicated program satisfaction and overall treatment success amongst the surveyed clients and family members.

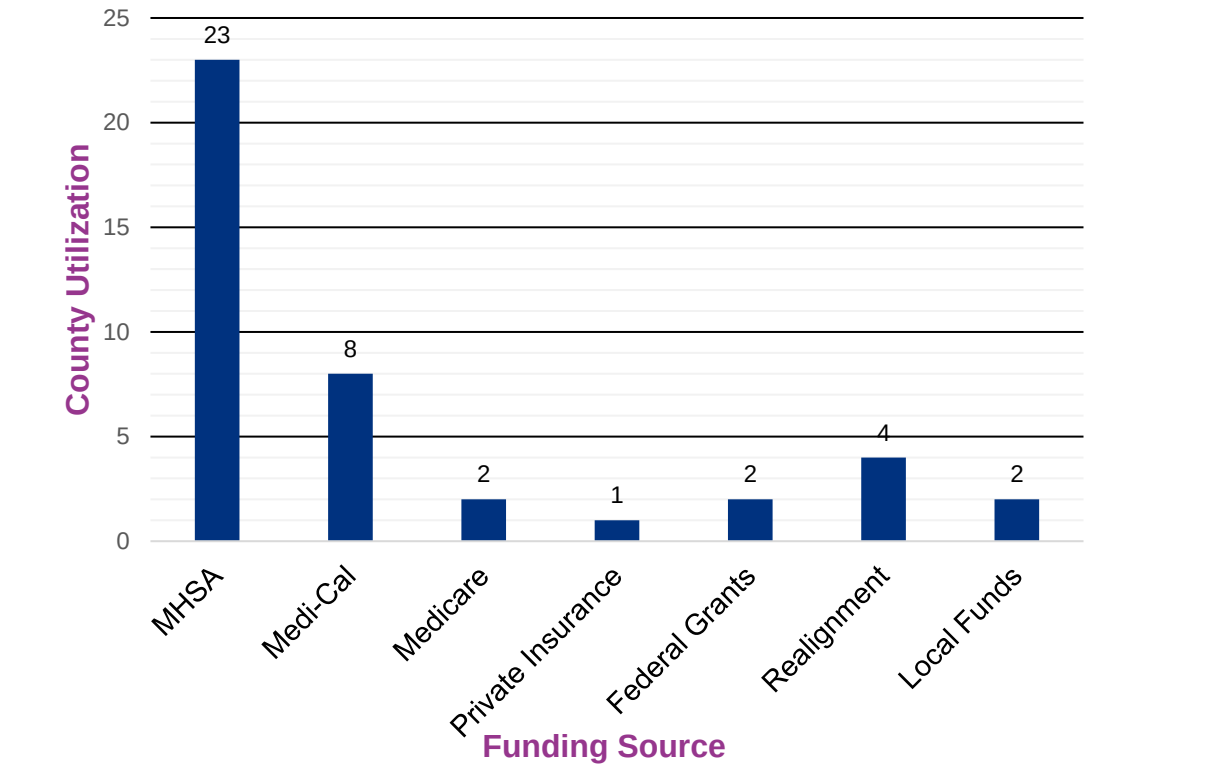
Funding Sources

Most counties rely on multiple funding sources to support their AOT programs, with MHSA being the most commonly used source. Some counties report using MHSA funding for outreach and engagement activities, and then utilizing Medi-Cal or other forms of health insurance once an individual receives placement at a provider. Other sources reported include, county general funds, local behavioral health funds, and grants. (See Figure 2. Overview of AOT Funding Sources for July 1, 2019 - June 30, 2020 SFYfor more information on the number of counties that used various funding

[15] ACT is an evidence-based mental health service delivery model for individuals with severe mental illness, and is widely considered complementary to AOT services.

sources.)

Figure 2. Overview of AOT Funding Sources for July 1, 2019 - June 30, 2020 SFY



Data Source: Data gathered from the DHCS Annual AOT Survey
Dates Represented: July 1, 2019 - June 30, 2020 State Fiscal Year (SFY)
Prepared by the California Department of Health Care Services

Areas of Significant Cost Reduction

Counties report considerable financial investment in order to comprehensively address the needs of the vulnerable AOT population. Some counties also report that investments made in the AOT program result in significant cost savings for the counties, such as decreased involvement with the criminal justice system, including reduced interactions with law enforcement and reduced frequency and duration of incarceration. Another area of significant cost reduction was a decrease in the number of psychiatric and non-psychiatric hospitalizations of participants. Nevada County reported that for every dollar invested, $1.81 was saved. The savings were primarily due to reduced psychiatric and non-psychiatric hospitalizations and placements for participants.

AOT and COVID-19

As a result of the COVID-19 public health emergency, physical and behavioral health issues have increased. Social distancing in particular has proven to have a negative impact on the mental health of many Californians. The Center for Disease Control and Prevention has reported a national increase in suicidal ideation, anxiety and depression. According to the article, *"The Impact of COVID-19 on Individuals Living with Serious Mental Illness (SMI),*[16] "social distancing can make individuals with SMI experience significant emotional distress, and relapse of psychotic symptoms, resulting in increased risk of re-hospitalization in this population." These challenges posed an extraordinary risk to the vulnerable AOT population.

In an effort to capture the impact to AOT programs as a result of the COVID-19 response, DHCS included survey questions related to funding, service delivery modifications, and new housing programs. The largest programmatic impacts due to COVID-19 were court closures and the limited access to AOT clients and referred individuals. Many court petitions and referral investigations were delayed during shelter-in-place orders. Three counties reported a significant decrease in the number of referrals to the program. In some counties, AOT administrative staff were activated as disaster workers, which precluded outreach opportunities. Additionally, visitation to jails and hospitals were restricted, limiting the ability of staff to engage with referred individuals. The COVID-19 emergency also delayed the operational start date for three newly implemented counties, with one county citing staffing shortages as the primary reason.

Despite the innumerable challenges, all counties maintained treatment services during this time, and were resourceful in order to continue serving AOT clients. Programs followed safety guidelines and used personal protective equipment, including masks and gloves, to continue to meet with individuals face-to-face to the extent possible. Counties reported successful transitions to utilizing virtual services as needed. Many staff members took tablets and mobile phones into the field to facilitate virtual appointments. San Diego County utilized Coronavirus Aid, Relief, and Economic Security Act aid to purchase tablets and smart phones for this purpose. Alameda County provided AOT clients with prepaid cellphones to access telehealth appointments. An additional challenge was the lack of available housing resources. Many counties coordinated with Project Roomkey,[17] and seven counties reported that AOT clients found shelter through this program. Overall, counties were able to

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[16] The Impact of COVID-19 on Individuals With Serious Mental Illness

[17] Project Roomkey was established as part of the state response to COVID-19 in order 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

overcome many dilemmas caused by the COVID-19 public health emergency, and continued their commitment to caring for the AOT population.

Court-Involved Findings

DHCS collects specified data to evaluate the effectiveness of the strategies employed by each program operated, as outlined in WIC 5348(d). Statute does not require counties or DHCS to evaluate data on voluntary participants. 258 participants were served within the following 15 counties by court order or court settlement: Alameda, Contra Costa, Kern, Los Angeles, Marin, Mendocino, Nevada, Orange, Placer, San Diego, San Francisco, Santa Barbara, Solano, Stanislaus, and Ventura. The following outcomes are organized by the required data elements, with demographic information listed first.

Demographic Information

Table 4. Demographics of AOT Court-Involved Individuals for July 1, 2019 - June 30, 2020 SFY[18]

Demographic	Total	% of Total
Court Process Type		
Court Order	123	48%
Court Settled	135	52%
Total	258	100%
Sex/Gender		
Female	85	33%
Male	173	67%
Transgender	0	0%
Total	258	100%
Age Categories		
18-25	37	14%
26-49	170	66%
50+	51	20%
Total	258	100%
Race/Ethnicity		
Caucasian/White	93	36%
Black/African American	34	13%
Hispanic/Latino	70	27%
Other, Multi-race, Unknown	61	24%
Total	258	100%

[18] Percentages are derived from 258 total court-involved participants.

Homelessness/Housing

Homelessness among participating clients was reduced by 32 percent during AOT, as compared to before program participation. This was a significant reduction, with an increase in the number of clients maintaining housing while in the AOT program. Ten counties reported that court-involved individuals successfully obtained housing through the AOT program. Nevada, San Francisco and Orange County noted that individuals who experienced housing instability during the program had fewer homeless days than prior to the AOT program. Kern, Mendocino, and Santa Barbara County reported that all participants avoided homelessness while receiving AOT services.

Hospitalization

Hospitalizations were reduced by 40 percent during AOT, as compared to before program participation. Seven counties reported a decrease in the number of days participants were hospitalized and in the frequency of psychiatric hospitalization. Additionally, seven counties reported an over 50 percent reduction in hospitalizations among court-involved participants. Eleven counties reported the use of crisis interventions to avoid hospitalizations.

Law Enforcement Contacts

Law enforcement contacts were reduced by 42 percent during AOT, as compared to before program participation. Los Angeles and Mendocino County in particular reported over 50 percent reduction in law enforcement contact. In addition, six counties that reported incarcerations of court-involved participants during AOT noted reductions in the number of days incarcerated per individual.

Treatment Participation / Engagement

Each county provided data on AOT court-involved individuals' adherence to treatment, whether or not they maintained contact with their program, 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 43 percent of court-involved participants adhered to their treatment plans, and 59 percent maintained contact with their program. 41 percent of court-ordered participants entered treatment voluntarily when re-petitioned. Eight counties reported one or more of the following indicators of successful engagement: increased participation, program completion, substance use treatment completion, improved family relationships, and parole/probation compliance.

Employment and Education

Counties reported that a majority of AOT court-involved participants had challenges in obtaining and/or maintaining employment while in treatment. Although programs focus primarily on treatment and recovery, many also offer and encourage engagement in a variety of employment services including, but not limited to: vocational training, community volunteer work, and resume writing classes. AOT programs may additionally offer or refer participants to educational services (e.g. general education development assistance). Seven counties reported that court-involved individuals participated in educational and/or employment services. In addition, five counties reported gainful employment for some participants.

Victimization

Historically, counties have reported individuals' reluctance to divulge their experiences of being victimized, both prior to and during AOT. Participants, especially those in the early stages of accepting treatment and recovery, may refuse additional assessments and/or decline to answer victimization questions. All counties have noted several limitations in fulfilling this required element. The available data suggests that victimization was reduced by 72 percent during AOT, as compared to before program participation.

Violent Behavior

Mirroring victimization, counties report similar limitations in reporting this required element. Many 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 63 percent during AOT, as compared to before program participation.

Substance Abuse

The majority of individuals in AOT are living with co-occurring diagnoses, including mental illness with substance use disorder (SUD). These participants need concurrent treatment, but the lack of integration of behavioral health services was reported as a barrier to access in some counties. Overall, substance abuse was reduced by 21 percent for court-involved individuals during AOT. Some counties reported successful SUD treatment completion among participants.

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 client-centered services that are culturally, gender, and age 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 three per week, for approximately 60 minutes per service during this reporting period.

Enforcement Mechanisms

Enforcement mechanisms to encourage and ensure treatment plan compliance may include, but are not limited to: increased number of update hearings, medication outreach and engagement, family meetings, and/or assessments for potential hospitalizations. Additional status hearings for the purpose of psychiatric evaluation are the most common, followed by court order renewals[19]. Six of the 15 counties that served court-involved participants reported utilizing enforcement mechanisms.

Social Functioning

Examples of social functioning include the ability to interact positively with staff, participation in extracurricular activities, and building peer relationships. Five out of fifteen counties provided data on social functioning prior to and during AOT participation.[20] Of these, four counties reported improvement in this area for 50 percent or more of their court-involved participants; the remaining county reported no improvement. Four counties did not collect data on social functioning before AOT, but each of these counties reported markers of good social functioning during the program for all or most participants.

Independent Living Skills

Independent living skills include stress management, food preparation, good hygiene, and the ability to utilize transportation. Similar to social functioning measures, five of fifteen counties provided data on independent living skills prior to and during AOT participation.[21] Four of these counties reported improvement for 50 percent or more of their court-involved participants; one county reported a slight decrease in skills. Five counties did not collect data on independent living skills before AOT, but each of these counties reported that all or most participants demonstrated good independent living

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[19] Counties may opt to renew a petition nearing the end of the initial 180 days of treatment if evaluation of the participant presents cause.

[20] As outlined in WIC 5348(d), counties must provide data on required elements, if available. Social functioning data was not available for six counties.

[21] As outlined in WIC 5348(d), counties must provide data on required elements, if available. Independent living skills data was not available for five counties.

skills during the program.

Discussion

The needs of participants eligible for AOT vary significantly; thus, strategies used to promote participant welfare reflected an eclectic approach. Counties engaged in comprehensive methods of outreach to locate and assess individuals, some of whom were experiencing crisis. Throughout the AOT program, behavioral health staff connected participants with access to shelter, vocational and educational training, medication, counseling, and additional resources to aid in recovery. County data indicated success in a variety of different measures, including reductions in homelessness, hospitalizations, and contact with law enforcement.

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, there is no comparison and/or control group; 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. DHCS requests the number of individuals who served in a previous reporting period; however, data outcomes for these individuals remain aggregated with the other court-involved participants.

The AOT program lacks a centralized database to submit the required data, and counties utilize varying systems to collect information. Although DHCS has attempted to leverage existing county reporting systems, those efforts have not been successful, as existing databases do not encompass the required data elements. DHCS will conduct an evaluation of the survey tool and make enhancements, where appropriate, to further address limitations. Despite these limitations, DHCS' analysis suggests overall significantly improved outcomes for AOT program participants.

Conclusion

The aggregate outcomes of the 258 court-involved individuals, served across 15 counties, indicated success in reducing homelessness, hospitalizations, and incarcerations for the July 1, 2019 - June 30, 2020 SFY reporting period.

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[22], 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)

Forty-seven 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.

[22] 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, 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 assisted outpatient treatment 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 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.
- Participation in the assisted outpatient treatment 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 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.