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

For the Reporting Period
May 2015 – April 2016

Department of Health Care Services
Mental Health and Substance Use Disorder Services

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EXECUTIVE SUMMARY

Assembly Bill (AB) 1421 (Thomson, Chapter 1017, Statutes of 2002) established the Assisted Outpatient Treatment Demonstration Project Act of 2002 in Welfare and Institutions Code (WIC) Sections 5345 – 5349.5, known as Laura's Law (named after one of the individuals killed during a 2001 incident in Nevada County, California). Laura's Law requires the Department of Health Care Services (DHCS) to establish criteria and collect outcomes data from counties that choose to implement the AOT program and produce an annual report on the program's effectiveness to the Legislature by May 1. Using the data collected, DHCS is required to provide an evaluation of the effectiveness of the county programs in developing strategies to reduce the clients' risk for homelessness, hospitalizations, and involvement with local law enforcement. This report serves as the May 1, 2016, annual report and provides outcomes for the May 2015 – April 2016 reporting period.

The table below shows a list of counties who have received Board of Supervisors approval to operate an AOT program, counties that submitted an AOT report to DHCS and, of those, which county AOT reports included data. Fifteen counties have Board of Supervisors approval to operate an AOT program: Alameda, Contra Costa, El Dorado, Kern, Los Angeles, Mendocino, Nevada, Orange, Placer, San Diego, San Francisco, San Luis Obispo, San Mateo, Ventura, and Yolo. During this reporting period, six counties submitted reports to DHCS: Kern, Los Angeles, Nevada, Orange, Placer, and San Francisco. Four of these counties had data to report on AOT court ordered or settled[1] individuals: Nevada, Orange, Placer and San Francisco. The remaining two programs did not have court ordered individuals, and therefore no data to report to DHCS, but provided information on their programs' progress. Accordingly, this report reflects aggregate outcomes for 28 individuals from the four counties that reported court-ordered or settled AOT client data to DHCS.

Table: Participating County Implementation and Reporting Status

County	Board of Supervisors Approval	Submitted a Report to DHCS	Report Included AOT Data
Alameda	X		
Contra Costa	X		
El Dorado	X		
Kern	X	X	
Los Angeles	X	X	
Mendocino	X		
Nevada	X	X	X
Orange	X	X	X
Placer	X	X	X
San Diego	X		
San Francisco	X	X	X
San Luis Obispo	X		
San Mateo	X		
Ventura	X		
Yolo	X		

[1] Court "settled" means that the individual receives services through a court settlement, rather than a hearing.

2015-16 Report Summary

There are two important developments for this reporting period: 1) more counties provided data on AOT clients compared to the 2014-15 fiscal year report and 2) all counties that provided data to DHCS reported positive impact on the three data items emphasized by the statute governing AOT (WIC Sections 5345-5349.5) – homelessness, hospitalizations, and incarcerations.

In addition to these two developments, DHCS notes from county reported data of the programs so far is that there are fewer individuals entering the AOT programs as a result of court orders or settlements. Laws governing AOT programs require individuals whose cases are court-ordered or settled to receive services in a program that also provides the same services to individuals who are participating in the program voluntarily. Individuals referred for an AOT assessment must be offered voluntary services first before a court petition is considered. The programs reported that the majority of their AOT referrals responded to the initial invitation to voluntary services and did not require a court petition or process. Counties report that this is due to the initial engagement process, which is successful as most individuals referred for assessment accept the first offer for voluntary services.

Due to the small number of court-ordered or settled individuals in each county AOT program, health privacy laws prevent DHCS from reporting specific numbers on each of the required outcomes. This report reflects the following aggregate findings for the AOT program clients using data for the four counties that reported data from their AOT services that were provided during the Fiscal Year 2015-16 reporting period:

- The number of individuals who were homeless prior to participating in the program decreased.
- The number of individuals who were hospitalized prior to participating in the program decreased.
- The number of individuals who had contact with law enforcement prior to entering the program decreased.
- Most individuals remained fully engaged with services.
- Some individuals were able to secure employment.
- No victimization[2] was reported for individuals in the program.
- Violent behavior decreased during the reporting period for some individuals.
- Some clients had co-occurring diagnoses. The majority of those individuals were able to reduce substance use.
- Some clients were subject to enforcement mechanisms[3] ordered by the court during AOT. Some of these individuals were involuntarily evaluated, none

[2] Victimization is based on county definitions and reports of victimization include descriptions of the incidents.

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

received an increase in status hearings, and many received medication outreach.
- Many individuals achieved moderate to moderately high levels of social functioning.
- Some clients agreed to participate in satisfaction surveys and indicated high levels of satisfaction with services.

There are several noteworthy limitations of DHCS' analysis. Although the reportable data has increased from additional counties providing AOT programs, court ordered participant numbers remain small and counties are not using standardized measures. This makes it difficult to make a comparable evaluation across counties, and it is unknown if all of the improvements in participant outcomes were a result of AOT program services, or if other factors were responsible. Some of the measures are based on self-reports and/or recollections of past events, which may or may not be accurate. Furthermore, individuals were followed for different periods of time (e.g., individual A may have been followed for one week, while individual B may have been followed for the entire reporting year). As with other programs that have transitory populations in different phases of program completion, there may be carry over data from the prior reporting year. Despite these limitations, DHCS' analysis indicates improvements to many of the reported outcomes for individuals who were served during this reporting period.

INTRODUCTION

AB 1421 (Thomson, Chapter 1017, Statutes of 2002) established the Assisted Outpatient Treatment (AOT) Demonstration Project Act of 2002, known as Laura's Law. The Department of Health Care Services (DHCS) is required to annually report to the Legislature on the effectiveness of AOT programs. The effectiveness is evaluated, pursuant to Welfare and Institutions Code (WIC) Section 5348, by whether persons served by these programs:

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

To the extent data are available, DHCS must also report:

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

AB 1569 (Allen, Chapter 441, Statutes of 2012) extended the sunset date for the AOT statute from January 1, 2013, to January 1, 2017; and AB 59 (Waldron, Chapter 251, Statutes of 2016) extended the sunset date for the AOT statute until January 1, 2022. The program was transferred from the former Department of Mental Health (DMH) to DHCS and incorporated into DHCS' county mental health performance contracts with the enactment of SB 1009 (Committee on Budget and Fiscal Review, Chapter 34, Statutes of 2012).

The AOT statute provides a robust process for designated individuals who may refer someone to the county mental health department for an AOT petition investigation, required criteria, the option for voluntary services to be offered, and options for a court settlement rather than a hearing.

BACKGROUND

The statutory requirements for Laura's Law do not require counties to provide AOT programs and do not appropriate any additional funding for counties to implement; therefore, until recently, only Nevada has operated an AOT program (since 2008). The passage of SB 585 (Steinberg, Chapter 288, Statutes of 2013) authorized counties to utilize specified funds for Laura's Law services, as described in WIC Sections 5347 and 5348. Since the enactment of this legislation, the number of counties implementing AOT has increased. See Appendix A for a full history of AOT in California.

Implementation of Laura's Law

Fifteen counties have received approval from their Board of Supervisors to implement AOT programs or pilots. These counties include: Alameda, El Dorado, Contra Costa, Kern, Los Angeles, Mendocino, Nevada, Orange, Placer, San Diego, San Francisco, San Luis Obispo, San Mateo, Ventura and Yolo. Most AOT programs are still in early implementation and have few or no clients that are court ordered or settled.

Kern, Los Angeles, Nevada, Orange, Placer, and San Francisco counties submitted reports to DHCS on their AOT programs for the reporting period. Of these, Nevada, Orange, Placer and San Francisco counties had court ordered and/or settled individuals to report. Kern and Los Angeles Counties reported on their programs, but did not have any court ordered or settled individuals.

DATA COLLECTION AND REPORTING METHODOLOGY

Most counties include AOT programs as part of their Mental Health Services Act (MHSA) Full Services Partnership (FSP) programs. Welfare and Institutions Code §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. Therefore, the methodology for obtaining data for AOT clients for the required data items typically comes from all or part of the following sources:

- Client intake information
- MHSA FSP Outcome Evaluation forms
  - Partnership Assessment Form (PAF) – 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 partner 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) [4]
- Global Assessment of Functioning (GAF) – indicates the level of presence of psychiatric symptoms
- Mental Health Statistics Improvement Program (MHSIP) Consumer Surveys measure matters that are important to consumers of publicly funded mental health services in the areas of access, quality, appropriateness, outcomes, overall satisfaction, and participation in treatment planning

Counties collected and compiled the required information into written reports, which were submitted to DHCS. DHCS reviewed the reports and followed up with counties to clarify and confirm the data. Due to the small population sizes reported, AOT clients may be identifiable; thus, summary numbers for each of the specified outcomes cannot be publicly reported in order to protect clients' health information and privacy rights. DHCS has a strong public commitment to comply with federal and state laws pertaining to health information privacy and security.[5] In order for DHCS to satisfy its AOT program evaluation reporting requirement as well as protect individuals' health information, standards and procedures have been adopted to appropriately and accurately aggregate data as necessary.

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[4] This scale was developed from funding by a Substance Abuse and Mental Health Services Administration (SAMHSA) grant and designed by the California Association of Social Rehabilitation Agencies (CASRA) and Mental Health America Los Angeles (MHALA) 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 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.

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

FINDINGS FOR REPORTING PERIOD May 1, 2015 – April 30, 2016

Based on county reported data submitted, there are very few individuals entering the AOT programs as a result of court orders or settlements. Laws governing AOT programs require individuals whose cases are court-ordered or settled to receive services in a program that also provides the same services to individuals who are participating in the program voluntarily. Individuals referred for an AOT assessment must be offered voluntary services first, before a court petition is considered. The programs reported that the majority of their AOT referrals responded to the initial invitation to voluntary services and did not require a court petition or process. Counties report that this is due to the initial engagement process, which is successful as most individuals referred for assessment accept the first offer for voluntary services.

Although fifteen counties implemented an AOT program, the data summarized in this report reflect the four counties that had data for court-ordered or settled individuals. Data for these counties are aggregated, with unique highlights of each program listed first. The four counties' AOT programs collectively served a total of 28 individuals. This is an increase from the 10 individuals served by an AOT program in Fiscal Year 2014-2015.

Part I: Programs Serving AOT Court Involved Individuals – Nevada, Orange, Placer, and San Francisco Counties

County Program Unique Highlights

Nevada County has had the longest running program that includes court orders/settlements. Consistently during that time, the majority of the referred individuals accepted the program's invitation to participate in voluntary services rather than requiring a court order or settlement.

Orange County compared the reporting year to the prior year and determined that there were multiple cost reductions to the county from AOT services. For its AOT program participant group, there was a cost savings of $219,776 in the reduction of hospitalization days and $75,774 savings due to the reduction of jail days.

Placer County is in the early stages of providing AOT services to individuals.

San Francisco County has developed an AOT Care Team, which is responsible for AOT court petitions, and advocating for some AOT individuals with preexisting charges to be referred to collaborative courts such as Behavioral Health Court. Behavioral Health Court is focused on family support including offering resources such as a Family Liaison, information, and assistance navigating the mental health and criminal justice systems. San Francisco County has initiated a quarterly conference call with other counties that have implemented AOT to share information and experiences of AOT programs.

Demographic Information

The AOT programs reported that the majority of participating individuals were Caucasian males between ages 26 and 59. This is similar to the information from the last reporting period, which indicated the majority of individuals in the programs were males between 25 and 62 years of age identifying as Caucasian.

Homelessness/Housing

During the last reporting period, Fiscal Year 2014-2015, homelessness among those served decreased. For this reporting period, Fiscal Year 2015-2016, the AOT programs reported significant reductions in homelessness, with the majority of clients obtaining and maintaining housing while in the AOT program.

Hospitalization

In the last reporting period, many of the individuals who were hospitalized prior to the court order for the reporting period experienced decreases in their hospitalization days during treatment. This reporting period, most programs reported that the majority of clients with psychiatric hospitalizations prior to AOT either reduced days hospitalized after AOT or entirely eliminated hospitalizations.

Law Enforcement Contacts

In the last reporting period, a few individuals served had contact with law enforcement prior to AOT treatment; there were no contacts with law enforcement for these individuals during the reporting period. However, some individuals who did not have law enforcement contact prior to AOT treatment experienced incarceration during treatment.

For Fiscal Year 2015-2016, programs reported law enforcement contacts (measured as “days of incarceration”), were reduced for all individuals that had experienced incarceration days prior to AOT.

Treatment Participation / Engagement

For Fiscal Year 2014-2015, the majority of the individuals were able to engage and remain in services. For this reporting period, Fiscal Year 2015-2016, clients’ ability to engage and participate in treatment varied significantly. Counties indicated that programs focused on assisting individuals with critical symptoms who were reluctant to approach treatment. Most programs reported that clients were able to achieve at least moderate levels of engagement, which resulted in positive outcomes for reducing hospitalizations, incarcerations, and homelessness.

Employment

For Fiscal Year 2014-2015, some of the individuals in the AOT program participated in education activities, but no clients gained employment during the reporting period.

For this reporting period, Fiscal Year 2015-2016, a few counties reported that the individuals they served were employed while in the program. Generally, clients were either not far enough along in treatment to gain employment or the AOT program had not yet implemented employment services as a strong component.

Victimization

For Fiscal Year 2014-2015, few individuals in the AOT program experienced victimization. AOT program staff reported that some of the victimization was financial in nature. These individuals were supported by the AOT program to avoid further victimization.

For this reporting period, Fiscal Year 2015-2016, there were few reported instances of victimization for clients prior to AOT program participation, and none reported for individuals during their AOT program participation.

Violent Behavior

For Fiscal Year 2014-2015, none of the individuals demonstrated violent behavior. For Fiscal Year 2015-2016, though demonstrations of violent behavior did occur, the counties reported a decrease in the violent behavior over the course of the reporting period.

Substance Abuse

During the last reporting period, Fiscal Year 2014-2015, all of the individuals had co-occurring diagnoses, meaning that the individuals had both mental health and substance use disorder diagnoses. Many were able to significantly reduce their use of substances while they were in the AOT program. All were reported to have varying levels of challenge with this issue.

For this reporting period, Fiscal Year 2015-2016, most AOT programs could not report on the AOT program's impact on substance use due to lack of reporting by clients. However, one program reported a decrease in substance use from the majority of clients.

Enforcement Mechanisms

Of the enforcement mechanisms typically available to courts (e.g., orders for

assessment/hospitalization, medication outreach, status hearings), medication outreach, (e.g., visiting clients to discuss medication, counting medication, helping prepare medication boxes, etc.) was used most often to support individuals who were not accustomed to managing and regularly administering their own medications. Some used status hearings if an individual was missing appointments and their mental health was beginning to decompensate, with the intent of helping individuals re-focus on their treatment goals and self-care.

Social Functioning

For Fiscal Year 2014-2015, the majority of the reported individuals achieved moderate to moderately high levels of social functioning, as measured by the MORS.

For this reporting period, Fiscal Year 2015-2016, all AOT programs reported anecdotal information on clients' social functioning, generally based on the staff's ability to develop good rapport with the clients. Overall, AOT programs reported increased social functioning, with clients' ability to interact with staff and tolerate therapeutic interactions considered the initial significant outcome in this area.

Independent Living Skills

For the last reporting period, Fiscal Year 2014-2015, the majority of the clients were able to achieve independent living, which is defined as not requiring placement in a board and care or other supervised housing. Several individuals were able to make various improvements to their independent living skills and decrease their need for supportive living.

During this reporting period, Fiscal Year 2015-2016, most programs reported that the clients, especially those who were generally homeless or frequently hospitalized prior to the court order, needed guidance with a wide array of independent living skills, such as medication management, money management, housing maintenance, and activities of daily living (e.g., dental hygiene).

Satisfaction with Services

For the Fiscal Year 2014-2015 AOT report, Nevada County reported that they utilized the annual Mental Health Statistics Improvement Survey (MHSIP)-Adult Consumer Survey to obtain satisfaction data from clients, which is also currently utilized by County Mental Health Plans to comply with federal reporting requirements. County Mental Health Departments administer the survey for one week, two times a year, and report the data to DHCS. The MHSIP survey was conducted in May 2014 for the May 2014 – April 2015 reporting period. Of the clients who completed the survey, the majority indicated that they were satisfied with AOT services.

For this reporting period, Fiscal Year 2015-2015, most AOT programs leveraged the annual MHSIP to report this data. Because satisfaction surveys are voluntary, some

clients refused to complete them. AOT Programs that surveyed clients and families found that the majority responded positively about the program and services. Some programs have or are developing their own survey tool, as the MHSIP may not occur often enough or at the right time to capture the majority of clients.

Part II: Programs with No AOT Court Ordered Individuals – Kern and Los Angeles Counties

County Program Unique Highlights

Kern County began services in Fall 2015 and had only voluntary clients participate in an AOT program during the reporting period.

Los Angeles County also reported serving voluntary clients since 2010 in a pilot AOT program. The county then fully implemented and expanded its AOT program in 2015. Currently, Los Angeles County is focused on engagement strategies.

Summary of Programs

Kern and Los Angeles Counties reported their AOT programs' progress. These counties report serving only individuals that accepted voluntary services during this reporting period.

LIMITATIONS

There are several noteworthy limitations of DHCS' analysis. Although the addition of reportable data has increased from additional counties providing AOT programs, court ordered client numbers remain small and counties are not using standardized measures, which makes it difficult to make a comparable evaluation across counties. Therefore, it is unknown if all of the improvements were a result of AOT program services, or if other factors were responsible. Some of the measures are based on self-reports and/or recollections of past events, which may or may not be accurate. Furthermore, individuals were followed for different periods of time (e.g., individual A may have been followed for one week, while individual B was followed for the entire reporting year). As with other programs that have transitory populations in different phases of program completion, there may be carry over data from the prior reporting year.

Despite these limitations, DHCS' analysis suggests improved outcomes for AOT program clients served during the reporting period. Notably, the majority of clients referred for an assessment opt to engage in voluntary AOT program services after being offered those services as part of the assessment process.

OTHER COUNTY AOT ACTIVITIES

San Francisco County hosts a quarterly teleconference for counties that have implemented AOT to discuss program status and share input. DHCS will provide updates to this group, if requested, and may assist with outreach to other counties that are operating AOT that may not be aware of the group.

DISCUSSION

All of the individuals reflected in this report appeared to benefit from the increased level of services and supports provided by their AOT program treatment teams, as evidenced by reductions in hospitalizations, homelessness, contact with law enforcement, and substance use. With respect to individuals that have both substance use and mental health issues, it is important to understand that concurrently recovering from both represents enormous challenges, requiring a great deal of support and counseling.

Prior to participating in an AOT program, many individuals' experience with mental health treatment mainly involved locked facilities or hospitalization. Therefore, many clients had to adjust to forming relationships with supportive community mental health workers and to experience intensive services outside of a locked setting. The success of this adjustment was indicated by the engagement by most individuals in AOT programs overall, whether voluntary or involuntary. During the reporting period, all the individuals who were able to complete a satisfaction survey indicated that they were satisfied with the services and supports.

Although discussed as a data limitation above, the small number of individuals that require a court order or settlement, coupled with county reports that the majority of those referred for assessment prior to court petitions accept services on a voluntary basis, suggests that counties are making robust efforts to engage individuals on a voluntary basis and are limiting the use of court petitions.

CONCLUSION

Fifteen counties currently have Board of Supervisors approval to operate an AOT program. During this reporting period, six counties submitted reports to DHCS, four of which had data to report on AOT court ordered or settled individuals. The other remaining AOT programs did not report client data to DHCS, but provided information on their programs' progress. This report includes aggregate outcomes from 28 individuals from the four counties that reported court-ordered or settled AOT client data to DHCS.

The data indicates that the program assisted individuals with preventing the need for hospitalizations and/or incarcerations, as well as assisting with supported employment. DHCS recommends continuing to monitor the progress and effectiveness of the services in the programs, and ensure that any other counties that may choose to

implement this law report data to DHCS, as required.

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 an inpatient locked facility for a mental health 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, and the plan at the time 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 ended up homeless or imprisoned with very little or no mental health treatment.[6]

In 1999, the state of New York (NY) passed a law that authorized court-ordered AOT for individuals with mental illness and a history of hospitalizations or violence requiring that they participate in community-based services appropriate to their needs. The law was named Kendra's Law in memory of a woman who died after being pushed in front of a New York City subway train by a man with a history of mental illness and hospitalizations. Kendra's Law defines the target population to be served by the AOT programs 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." The program is required in all counties in NY and the individuals served by court order have priority for services. Kendra's Law improved a range of important outcomes for its recipients,[7] but differs from California's Laura's Law in two significant ways. It requires that all counties in NY implement AOT programs, and requires that the clients accessing these programs have priority for services.

Patterned after Kendra's Law, California passed AB 1421 (Thomson, Chapter 1017, Statutes of 2002), known as Laura's Law, that provides for court-ordered community treatment for individuals with a history of hospitalization and contact with law

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[6] For additional historical information, see Laura's Law legislative report 2011 at: http://www.dhcs.ca.gov/services/MH/Documents/4LaurasLawFinalReport.pdf

[7] See Kendra's Law, Final Report on the Status of Assisted Outpatient Treatment Outcomes for Recipients during the First Six Months of AOT [Office of Mental Health, State of New York 2005, http://www.omh.ny.gov/omhweb/kendra_web/finalreport/outcomes.htm] and the New York State Assisted Outpatient Treatment Program Evaluation [Swartz, MS et al. Duke University School of Medicine, Durham, NC, June, 2009, http://www.macarthur.virginia.edu/aot_finalreport.pdf].

enforcement. It is named after a woman who was killed in Nevada County by an individual with mental illness who was not following his prescribed mental health treatment. The legislation established an option for counties to utilize courts, probation, and mental health systems to address the needs of individuals who are unable to participate on their own in community mental health treatment programs without supervision. This has resulted in reductions in homelessness, incarceration, and hospitalization for these individuals. Laura's Law authorizes counties to implement an AOT program and specifies that funding for established community services may not be reduced to accommodate the program.