

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

For the Reporting Period
May 2016 – April 2017

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

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Table of Contents

EXECUTIVE SUMMARY 3
2016-17 Report Summary 4
INTRODUCTION 6
BACKGROUND 7
Implementation of Laura's Law 7
DATA COLLECTION AND REPORTING METHODOLOGY 8
FINDINGS FOR REPORTING PERIOD May 1, 2016 – April 30, 2017 10
Part I: Programs Serving AOT Court Involved Individuals – Contra Costa, Los Angeles, Nevada, Orange, Placer, and San Francisco Counties 10
County Program Unique Highlights 10
Demographic Information 11
Homelessness/Housing 11
Hospitalization 11
Law Enforcement Contacts 11
Treatment Participation / Engagement 11
Employment 12
Victimization 12
Violent Behavior 12
Substance Abuse 12
Enforcement Mechanisms 12
Social Functioning 13
Independent Living Skills 13
Satisfaction with Services 13
Part II: Programs with No AOT Court Ordered Individuals – El Dorado, Kern, Mendocino, San Diego, San Luis Obispo, San Mateo, Santa Barbara, Ventura, and Yolo Counties 14
County Program Unique Highlights 14
Summary of Programs 14
LIMITATIONS 15
DISCUSSION 15
CONCLUSION 16
Appendix A 17

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, which is due to the Governor and Legislature annually by May 1. Using data provided by participating counties, 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, 2017 annual report and provides outcomes for the May 2016 – April 2017 reporting period.

The table below shows a list of counties that 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 provided data to DHCS during this reporting period. Seventeen 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, Santa Barbara, Stanislaus, Ventura, and Yolo[1]. During this reporting period, 12 counties submitted reports to DHCS: Alameda, Contra Costa, Kern, Los Angeles, Mendocino, Nevada, Orange, Placer, San Francisco, San Mateo, Ventura, and Yolo. Six of these counties had data to report on AOT court ordered or settled[2] individuals: Contra Costa, Los Angeles, Nevada, Orange, Placer and San Francisco. The remaining six programs did not have court-ordered individuals or had too little data for the reporting year to report to DHCS, but provided information on their programs' progress. Accordingly, this report reflects aggregate outcomes for 63 individuals from the six counties that reported court-ordered or settled AOT client data to DHCS. This is more than double the number of participants compared to the previous 2015-16 reporting period, which included 28 court-involved individuals in AOT programs.

Participating County Implementation and Reporting Status (as of April 2017)*

County	Board of Supervisors Approval	Submitted a Report to DHCS	Report Included AOT Data
Alameda	X	X	
Contra Costa	X	X	X
El Dorado	X		
Kern	X	X	

[1] Stanislaus County received board of supervisor approval to implement a pilot program in April 2018. Since this occurred after the reporting period, data for Stanislaus is not reflected in this report.
[2] Court "settled" means that the individual receives services through a court settlement, rather than a hearing.

County	Board of Supervisors Approval	Submitted a Report to DHCS	Report Included AOT Data
Los Angeles	X	X	X
Mendocino	X	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	X	
Santa Barbara	X		
Stanislaus	X		
Ventura	X	X	
Yolo	X	X	

*Stanislaus County received board of supervisor approval to implement a pilot program in April 2018. Since this occurred after the reporting period, data for Stanislaus is not reflected in this report.

2016-17 Report Summary

There are three important developments for this reporting period: 1) two additional counties provided data on AOT clients as compared to the previous reporting period, 2) the six counties that provided data to DHCS reported a positive impact on the three data items emphasized by the statute governing AOT (WIC Sections 5345-5349.5) – homelessness, hospitalizations, and incarcerations, and 3) counties continue to report that few individuals require court involvement to participate in AOT services. In this reporting period, there were 63 court-involved individuals in the six counties that provided data[3].

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 participate in voluntary services, and did not require a court petition or process. Counties report that this is due to a successful initial engagement process, as most individuals referred for assessment accept the first offer for voluntary services. Many individuals, due to the symptoms of their mental illness, do not initially access local mental health services, but may accept a voluntary services offer

[3] 380 individuals were served voluntarily by the six counties reporting data, the majority were in Los Angeles and Orange counties.

in response to county engagement efforts and to avoid a court process.

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 six counties that reported data from their AOT services, which were provided during this reporting period:

- Homelessness decreased amongst individuals participating in the program.
- Hospitalization decreased amongst individuals participating in the program.
- Contact with law enforcement decreased amongst individuals participating in the program.
- Most individuals remained fully engaged with services.
- Some individuals were able to secure employment.
- Little victimization[4] was reported for individuals in the program.
- Violent behavior decreased during the reporting period for some individuals.
- Some clients had co-occurring diagnoses. Many of those individuals were able to reduce substance use.
- Some clients were subject to enforcement mechanisms[5] ordered by the court during AOT. Some of these individuals were involuntarily evaluated, many had additional 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 since additional counties have implemented 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 further, there is no comparison and/or control group, so it is unknown as to whether or not all of the improvements in participant outcomes were a result of AOT program services or if other factors were involved. Some of the measures are based on self-reports and/or recollections of past events, which may or may not be accurate or reliable. 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, the data submitted by counties indicate improvements to many of the reported outcomes for individuals who were served during this reporting period.

[4] Victimization is based on county definitions and reports of victimization include descriptions of the incidents.
[5] Examples of enforcement mechanisms used by courts include, but are not limited to, involuntary evaluation, increased number of status hearings, and medication outreach.

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. 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, and added the Governor as a direct recipient of this report. The program was transferred from the former Department of Mental Health (DMH) to the Department of Health Care Services (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).

DHCS is required to annually report to the Governor and Legislature on the effectiveness of AOT programs by May 1 of every year. Pursuant to WIC Section 5348, effectiveness of AOT programs is evaluated by determining whether persons served by these programs:

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

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

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

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

BACKGROUND

The statutory requirements for Laura's Law do not require counties to provide AOT programs and do not appropriate any additional funding to counties for this purpose. For many years, only Nevada County operated an AOT program. 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, an increasing number of counties have implemented AOT. See Appendix A for a history of AOT in California.

Implementation of Laura's Law

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 provided data to DHCS during this reporting period. Seventeen 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, Santa Barbara, Stanislaus, Ventura, and Yolo.[6] Most AOT programs are still in early implementation stages and have few or no clients who are court-ordered or settled.

The following 12 counties submitted reports to DHCS on their AOT programs for the reporting period: Alameda, Contra Costa, Kern, Los Angeles, Mendocino, Nevada, Orange, Placer, San Francisco, San Mateo, Ventura, and Yolo. Of these, Contra Costa, Los Angeles, Nevada, Orange, Placer, and San Francisco counties had data to report based on the individuals participating in their AOT programs that were court-ordered and/or settled. Kern and Yolo Counties reported on their programs, but did not yet have any individuals in AOT programs or did not have enough data to include. Alameda, Mendocino, San Mateo, and Ventura Counties reported on their new programs, but did not have clients during most of the reporting period, and therefore did not have enough data to include.

Participating County Implementation and Reporting Status (as of April 2017)*

County	Board of Supervisor Approval	Submitted a Report to DHCS	Report Included AOT Data
Alameda	X	X	
Contra Costa	X	X	X
El Dorado	X		
Kern	X	X	
Los Angeles	X	X	X
Mendocino	X	X	
Nevada	X	X	X
Orange	X	X	X

[6] Stanislaus County received board of supervisor approval to implement a pilot program in April 2018. Since this occurred after the reporting period, data for Stanislaus is not reflected in this report.

County	Board of Supervisor Approval	Submitted a Report to DHCS	Report Included AOT Data
Placer	X	X	X
San Diego	X		
San Francisco	X	X	X
San Luis Obispo	X		
San Mateo	X	X	
Santa Barbara	X		
Stanislaus	X		
Ventura	X	X	
Yolo	X	X	

* Stanislaus County received board of supervisor approval to implement a pilot program in April 2018. Since this occurred after the reporting period, data for Stanislaus is not reflected in this report.

DATA COLLECTION AND REPORTING METHODOLOGY

Most counties have implemented their 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. As a result, counties obtain data for AOT clients from some or all of the following sources:

- 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 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) [7]
- Global Assessment of Functioning – Indicates the level of presence of psychiatric symptoms.

[7] 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.

- Mental Health Statistics Improvement Program 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. Due to the small population sizes reported, AOT clients may be identifiable. DHCS is committed to complying with federal and state laws pertaining to health information privacy and security.[8] In order to protect clients' health information and privacy rights, summary numbers for each of the specified outcomes cannot be publicly reported. In order for DHCS to satisfy its AOT program evaluation reporting requirement, as well as protect individuals' health information, DHCS adopted standards and procedures to appropriately and accurately aggregate data, as necessary.

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

FINDINGS FOR REPORTING PERIOD May 1, 2016 – April 30, 2017

Based on county-reported data, there are very few individuals entering the AOT programs as a result of court orders or settlements. Individuals referred for an AOT assessment must be offered voluntary services 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 a successful initial engagement process, as most individuals referred for assessment accept the first offer for voluntary services.

Although 16 counties have implemented AOT programs, the data summarized in this report reflect the six counties that had data for court-ordered or settled individuals. Data for these counties are aggregated, with highlights of each program listed first. The six counties' AOT programs collectively served a total of 63 court involved individuals. This is more than double the number of participants as compared to the last reporting period, in which 28 individuals were in AOT programs.

Part I: County Programs Serving AOT Court-Involved Individuals – Contra Costa, Los Angeles, Nevada, Orange, Placer, and San Francisco

County Program Unique Highlights

Contra Costa County reported that, during its first year of operation, 91 percent of individuals referred for assessment for AOT services accepted voluntary services.

Los Angeles County reported serving voluntary clients since 2010 in a pilot AOT program. The county then fully implemented and expanded its AOT program in 2015. This is the first reporting year that Los Angeles has had court-ordered or settled AOT participants. As with the other counties, the Los Angeles court-ordered or settled participants are a fraction of its overall number of AOT participants.

Nevada County has had the longest running AOT program, dating back to 2008. Consistently over 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 noted that, while there was overall improvement in housing over the reporting period, participants still experienced challenges finding and maintaining housing.

Placer County continues to be in the early stages of providing AOT services to individuals and has a small number of participants.

San Francisco County has developed an AOT Care Team, which is responsible for AOT court petitions and advocating for 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 continues to host a quarterly conference call with other counties that have implemented AOT to share information and experiences of AOT programs.

Demographic Information

Counties 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 identifying as Caucasian between 26 and 59 years of age. Some counties reported seeing more racial diversity in their AOT populations, and more female participants.

Homelessness/Housing

In the previous reporting period, homelessness among those served decreased. For this reporting period, counties reported modest 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 receiving AOT services experienced decreases in their hospitalization days. This reporting period, most programs reported that the majority of clients with psychiatric hospitalizations prior to AOT either reduced their days of hospitalization during AOT or entirely eliminated hospitalizations.

Law Enforcement Contacts

In the last reporting period, programs reported law enforcement contacts (measured as “days of incarceration”) were reduced for all individuals that had experienced incarceration days prior to AOT. For this reporting period, this trend continues as all programs reported reductions in law enforcement contact for participants in AOT programs.

Treatment Participation / Engagement

For the previous reporting period, participants’ 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, and most participants were able to achieve at least moderate levels of engagement. For this reporting period, the majority of the participants again were able to engage in treatment and remain in contact with their programs. This continues to result in positive outcomes for reducing hospitalizations, incarcerations, and homelessness.

Employment

In the prior reporting period, few clients 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 component. For this reporting period, there was an increased level of employment for individuals across programs, including some participation in education.

Victimization

For the previous reporting period, there were few reported instances of victimization for participants prior to AOT program participation, and none reported for individuals during their AOT program participation. For this reporting period, there were again few reports of victimization, with some programs reporting that individuals were reluctant to share such information via the questionnaires that were used. These programs indicate that they will modify their questionnaires and/or programs to provide more comfortable means for individuals to share such sensitive information.

Violent Behavior

In the prior reporting period, counties reported an overall decrease in violent behavior. In the current reporting period, some programs reported violent episodes for individuals who were struggling with initial phases of stability, and other programs reported that the AOT program participants displayed decreased violent behavior or that they did not collect data on this outcome measure.

Substance Abuse

During the last 2015-16 reporting period, one AOT program reported a decrease in substance use for the majority of its clients; however, most AOT programs could not report on the AOT program's impact on substance use due to lack of information provided by the participants.

For the 2016-17 reporting period, all programs reported varying levels of challenges with participant substance use. The majority of individuals in AOT have co-occurring diagnoses, meaning that they have both mental health and substance use disorder diagnoses. This presents a complication for programs to support individuals in recovery from both issues. In some cases, the majority of individuals in the programs relapsed during AOT, while other programs reported the majority were able to avoid substance use.

Enforcement Mechanisms

For the last reporting period, medication outreach (e.g., visiting clients to discuss medication, helping prepare medication boxes) was the enforcement mechanism used most often to support individuals who experienced challenges in managing and regularly administering their own medications. Some programs used status hearings as a vehicle to help individuals re-focus on their treatment goals and self-care when they were

missing appointments and their mental health was beginning to decompensate.

For this reporting period, the most common enforcement mechanisms used were additional status hearings, with a small group of individuals receiving orders for hospitalization for the purpose of psychiatric evaluation. Some programs provided medication outreach as a regular support for their participants.

Social Functioning

For the prior reporting period, all AOT programs provided DHCS with anecdotal information on clients' increased social functioning, generally credited to the staff's ability to develop good rapport with the clients.

For this reporting period, overall, AOT programs reported increased social functioning and considered the participants' ability to interact with staff and tolerate therapeutic interactions a significant outcome in this area.

Independent Living Skills

For the last reporting period, most programs communicated to DHCS that the participants 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), especially those who were generally homeless or frequently hospitalized prior to the court order.

During this period, programs reported that the majority of individuals improved in their independent living skills, as indicated by improved scores on the Milestone of Recovery Scale, and demonstrated strengthened skills in stress management, improved hygiene, food preparation, and transportation.

Satisfaction with Services

For the last reporting period, most AOT programs leveraged the annual Mental Health Statistics Improvement Program to report satisfaction with services. 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.

For this reporting period, the majority of surveyed individuals were also satisfied with their services. Some programs have or are developing their own survey tool to capture individual responses that are unique to AOT programs rather than utilizing a pre-established survey, which include services beyond AOT.

Part II: Programs with No AOT Court Ordered Individuals – El Dorado, Kern, Mendocino, San Diego, San Luis Obispo, San Mateo, Santa Barbara, Ventura, and Yolo Counties

County Program Unique Highlights

El Dorado County is implementing AOT by conducting a pilot program and currently has voluntary clients.

Kern County began services in Fall 2015 and continues to have only voluntary clients during both the current and previous reporting periods.

Mendocino County has implemented a four-slot pilot program for AOT and had no court-ordered or settled participants.

San Diego County just completed the first year of their new program with no court-ordered or settled participants.

San Luis Obispo County is still in the early stages of implementing their new program.

San Mateo County assembled a team consisting of a Clinical Services Manager, one half-time Psychologist, one Psychiatric Social Worker, one half-time Deputy Public Guardian and two half-time Peer Support Workers that travel throughout the county to evaluate individuals and provide referrals to services if needed. San Mateo County includes a Peer Support Worker to enhance engagement and support for individuals encountering the AOT program.

Santa Barbara County did not have a full year of the new program for this reporting period and did not have any court-ordered or settled participants.

Ventura County recently began receiving individuals, but did not have any during the reporting period.

Yolo County has a five slot AOT program, which was implemented three years ago. To date, it has only voluntary individuals have utilized the program.

Summary of Programs

The numbers of individuals participating in AOT services statewide has increased since more counties have implemented AOT programs. Programs report that ongoing efforts to develop robust engagement and support strategies have led to more engaged participation in AOT programs and voluntary participation in AOT services. With continued success in this area, programs are likely to maintain low numbers of individuals that require court involvement.

LIMITATIONS

There are several noteworthy limitations of DHCS' analysis. Although participating counties have provided additional data, court ordered client numbers remain small. The small population size makes it difficult to determine if the data allows for statistically significant conclusions. Additionally, counties are not using standardized measures, which makes it difficult to make comparisons across counties. Further, there is no comparison and/or control group, so it is unknown as to whether or not the improvements were a result of AOT program services, or other factors. Some of the measures are based on self-reports and/or recollections of past events, which may or may not be accurate or reliable. 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 period). As with other programs that have transitory populations in different phases of program completion, there may be carry over data from the prior reporting period.

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

DISCUSSION

The data provided by counties suggest that individuals have benefited from participation in AOT programs, 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 and requires a great deal of support and counseling. Some counties found that there were challenges with participants relapsing and at times relapses lead to further psychiatric hospitalizations.

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 receiving 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, and by the majority of individuals who completed a satisfaction survey indicating that they were satisfied with the services and supports.

Counties continue to report that only a small fraction of their overall AOT program populations (voluntary plus involuntary individuals) require a court order or settlement to participate. This suggests that counties are maintaining a strong effort to engage individuals in voluntary services and avoiding the court petition process.

CONCLUSION

Seventeen counties currently have Board of Supervisors approval to operate an AOT program. During this reporting period, 12 counties submitted reports to DHCS, six of which had data to report on AOT court-ordered or settled individuals. The other reporting AOT programs did not have court-ordered or settled client data to report to DHCS, but provided information on their programs' progress. This report includes aggregate outcomes from 63 individuals from the six counties that reported court-ordered or settled AOT client data to DHCS.

The data indicates that the program was successful in reducing the need for hospitalizations and/or incarcerations, largely due to an increased amount of support, and increasing employment during this reporting period. DHCS recommends continuing to monitor the progress and effectiveness of the services in the programs as counties develop and expand their programs, and ensuring that any other counties that choose to implement Laura's 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 intent 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.[9]

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,[10] 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

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

[10] 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].

treatment for individuals with a history of hospitalization and contact with law enforcement. It is named after a woman who was one of three 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. 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. Laura's Law has resulted in reductions in homelessness, incarceration, and hospitalization for these individuals.