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

For the Reporting Period
July 1, 2020 – June 30, 2021

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

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Executive Summary

Assembly Bill (AB) 1421 (Thomson, Chapter 1017, Statutes of 2002) established the Assisted Outpatient Treatment (AOT) Demonstration Project Act of 2002 in Welfare and Institutions (W&I) Code sections 5345 – 5349.1, known as Laura's Law. Provisions of Laura's Law require the Department of Health Care Services (DHCS) to collect data outcomes from counties that have implemented[1] the AOT program, and 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, 2022 annual report, and provides statewide programmatic updates and aggregate outcomes[3] for 197 individuals from 11 counties that reported court-involved[4] client data to DHCS for State Fiscal Year (SFY) July 1, 2020 – June 30, 2021. The 11 counties are Alameda, Contra Costa, Kern, Los Angeles, Mendocino, Nevada, Orange, Placer, San Diego, San Francisco, and Ventura.

[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 – 81 percent[5] of eligible individuals responded to the initial invitation for voluntary services and did not require a court petition or process.

Key Highlights:

- ▼ Homelessness decreased by 26 percent.
- ▼ Hospitalization decreased by 51 percent.
- ▼ Contact with law enforcement decreased by 70 percent.
- \+ Twenty-five percent of individuals were able to secure employment or participated in employment and/or educational services.
- ▼ Victimization decreased by 67 percent.
- ▼ Violent behavior decreased by 80 percent.
- ▼ Substance abuse was reduced by 29 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. Due to the COVID-19 public health emergency, accessibility to clients and services were limited by safety protocols in place and court closures. Despite this, counties were resourceful in utilizing virtual services to continue operations and vaccinations were accessible to AOT participants in 16 counties.
2. The enactment of AB 1976 (Eggman, Chapter 140, Statutes of 2020) resulted in statewide expansion of AOT services.
3. Nineteen percent of referred individuals who met AOT criteria required court involvement to participate in AOT services.
4. Aggregate outcomes indicated a positive impact on the three outcome elements mandated by the statute governing AOT – homelessness, hospitalizations, and incarcerations.

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

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 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 services, either independently or in a partnership with neighboring counties, unless the county elects to opt out in specified ways. AB 1976 repealed the sunset date of Laura's Law, extending the program indefinitely. Additionally, AB 1976 added a superior court judge as an eligible petitioner for AOT services to be filed for a person who appears before the judge. On 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) broadened the criteria to permit AOT for a person who is in need of such services, without also requiring that the person's condition be substantially deteriorating. This bill additionally required the examining mental health professional, in their affidavit to the court, to determine if the subject of the AOT petition has the capacity to give informed consent regarding psychotropic medication.

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

AOT Across California

As a result of AB 1976, AOT services will now be available in over 50 percent of the state's counties, spanning many suburban, urban, and rural areas. By December 2023, all 31 counties that have opted to implement AOT will be fully operational to provide services. DHCS will continue to provide technical assistance and training on AOT legislative reporting requirements with the anticipation that more California counties may opt in to provide AOT.

Figure 1. AOT in California
California Counties with Assisted Outpatient Treatment Programs[8]

Counties and Operational Year

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

[8] "Operational year" is the year that implemented counties began operating to provide services.

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.

In 2022, DHCS conducted an annual review of the data collection methodology for the Laura's Law Legislative Report in order to address continued data limitations (i.e., referral data) and further standardize the data collection process. As a result, DHCS

[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 from 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.

issued a Behavioral Health Information Notice[11] to provide counties with updated guidance and reporting requirements. All counties reported available data outcomes for the July 1, 2020 – June 30, 2021 SFY with DHCS guidance, which included the use of the AOT Data Dictionary and AOT Outcome Evaluation.[12]

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.[13] 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[14] 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] Behavioral Health Information Notice No: 22-035

[12] The AOT Outcome Evaluation (formally AOT Survey Tool) is distributed and completed via a web-based survey platform.

[13] 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 Part 160 and Subparts A and E of 164. State Laws: Information Practices Act and California Civil Code Sections 1798.3, et. seq.

[14] The DHCS Data De-identification Guidelines (DDG) v2.0 is based on the California Health & Human Services Agency DDG, which is focused on the assessment of aggregate or summary data for purposes of de-identification and public release. For additional information and to view DDG, see the Public Reporting Guidelines on DHCS' webpage.

Findings for the July 1, 2020 – June 30, 2021 SFY Reporting Period

Statewide Findings

In SFY 2020-21, 1,914 individuals were referred to AOT during this reporting period across all 20 counties[15] with operational AOT programs. Collectively, the reported average[16] amount of time spent by counties investigating the eligibility of a referral is approximately 61 days. As shown in Chart 1, most counties reported that many referred individuals were not enrolled in AOT; these individuals may or may not have been deemed eligible or were found to no longer meet AOT criteria after initial contact with AOT teams. These individuals were given the opportunity to access alternative behavioral health treatment services or short-term case management services until connected to more appropriate care.

Of the total referrals received shown in **Error! Reference source not found.**, 1,014 individuals were found eligible for AOT, 567 individuals were found to be ineligible, 268 were unable to be located[17] and 65 were either pending investigation at the time of reporting or were placed into a category not required to be reported by DHCS.

Of the total referrals determined to be eligible shown in Chart 3, 817 individuals responded to the initial invitation to voluntary services and did not require a court petition, and 197 individuals entered AOT as a result of court orders or settlements.

[15] DHCS previously included Mariposa, Napa, and Tulare counties as operational during the SFY 2019-2020 reporting period; however, upon further review DHCS determined the status of those counties to be either implemented but not yet fully operational or operational in a pilot stage of implementation; and they are therefore excluded from the total number of operational counties during the reporting period for this report.
[16] Averages are weighted throughout the report.
[17] Counties often attribute loss of contact with participants to individuals leaving a county once they are notified of an investigation. Counties additionally report that some individuals are eventually located and reengaged for services. These individuals may or may not be included in this report.

Chart 1. Overview of Statewide Referrals Not Enrolled in AOT for SFY 2020-21[18]

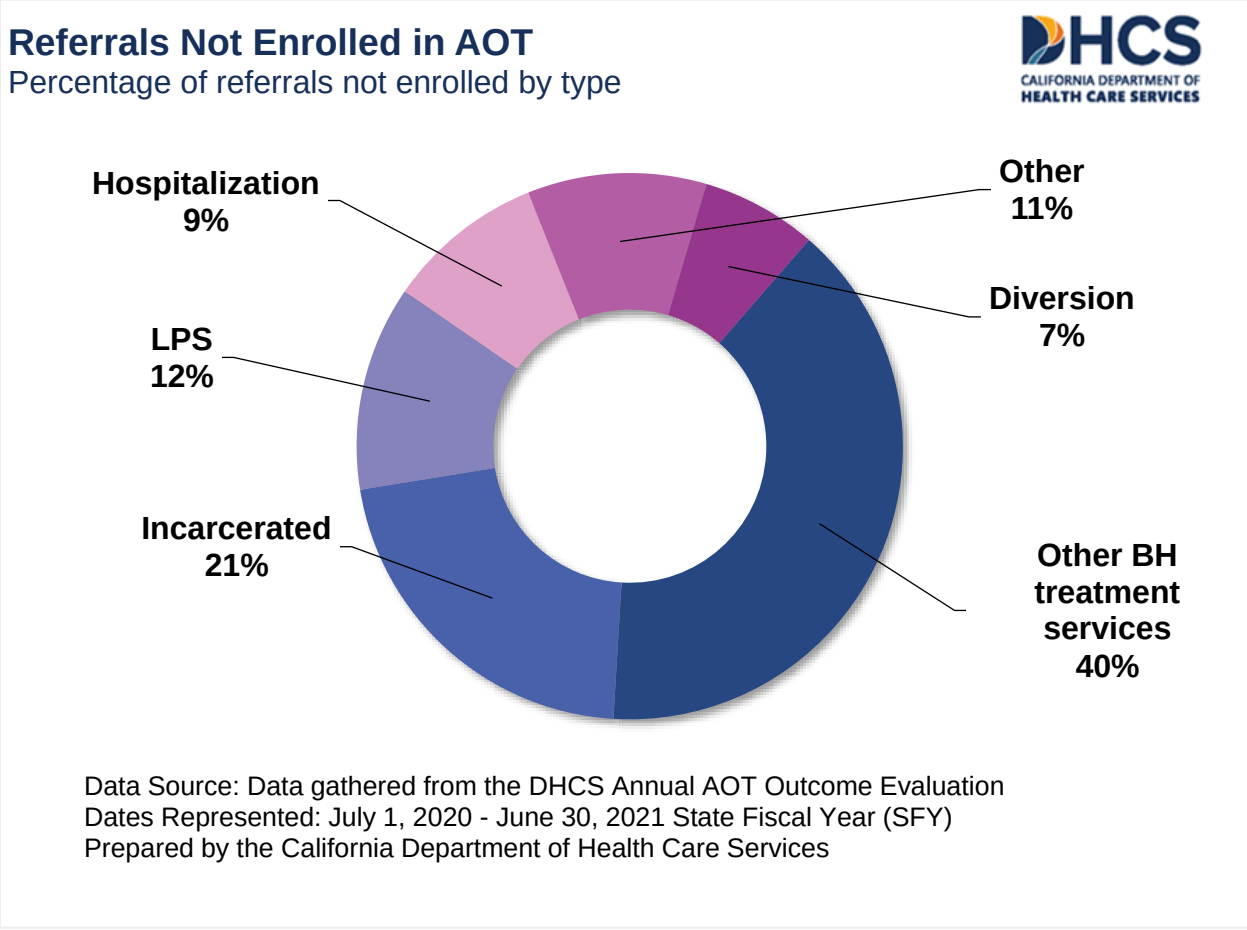


Table 1. Referrals Not Enrolled: Count of referrals per category

Referrals Not Enrolled	Count
Other behavioral health treatment services	127
Incarcerated	69
Lanterman-Petris-Short (LPS)[19]	39
Hospitalization	30
Diversion	22
Other	34
Total	321

[18] DHCS previously reported on the number of referrals that were categorized as "other"; this data is now reported as "referrals not enrolled in AOT" in order to account for referrals that apply for other categories which are not required to be reported by DHCS. This data could not be combined with referral eligibility due to aggregated and/or potential duplication of data.
[19] For information about LPS refer to Appendix A.

Chart 2. Overview of Statewide Referral Eligibility for SFY 2020-21

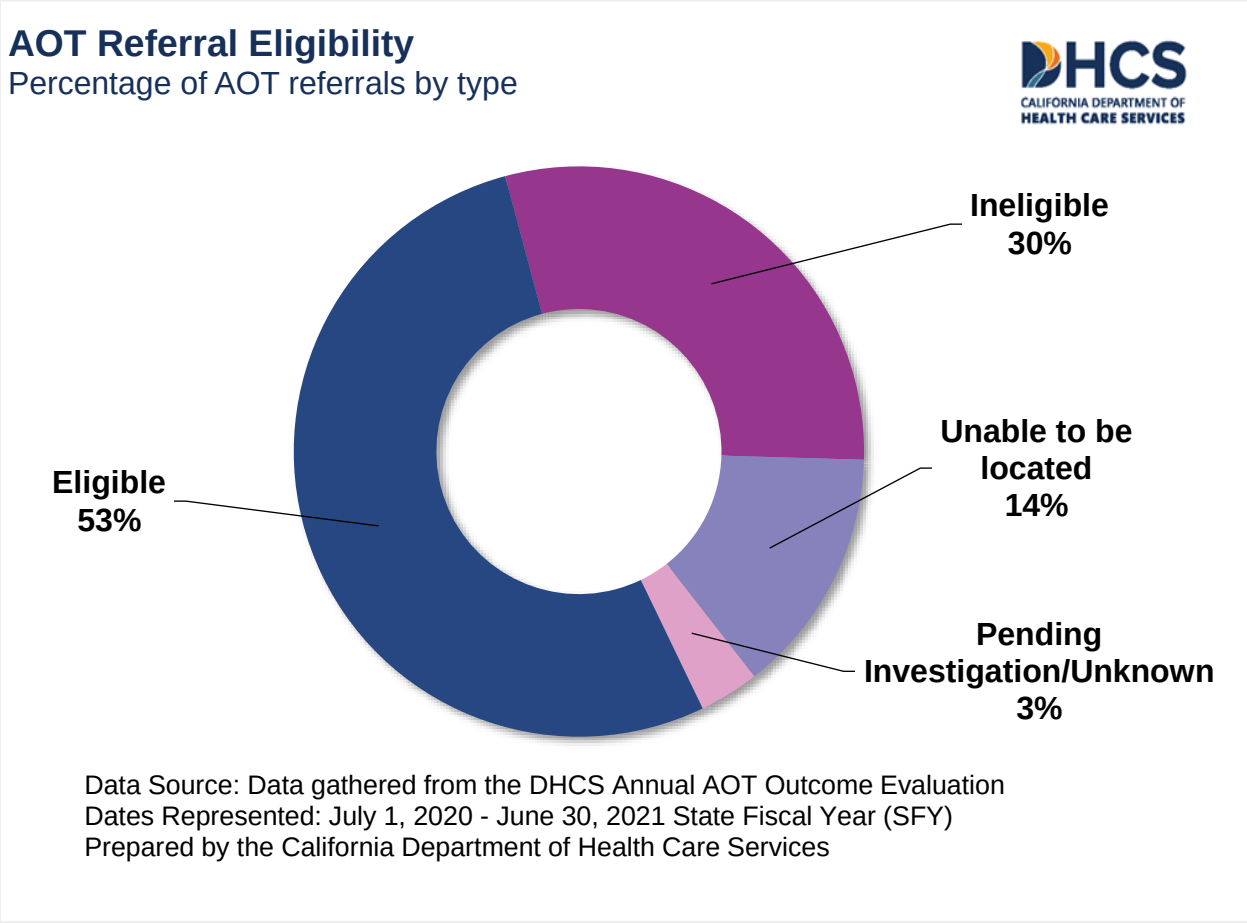


Table 2. Total Referral Eligibility: Count of referrals by type

Referrals	Count
Ineligible	567
Unable to be located	268
Pending Investigation/Unknown[20]	65
Eligible	1,014
Total	1,914

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

Chart 3. Overview of Total Enrollment of Eligible Referrals for SFY 2020-21

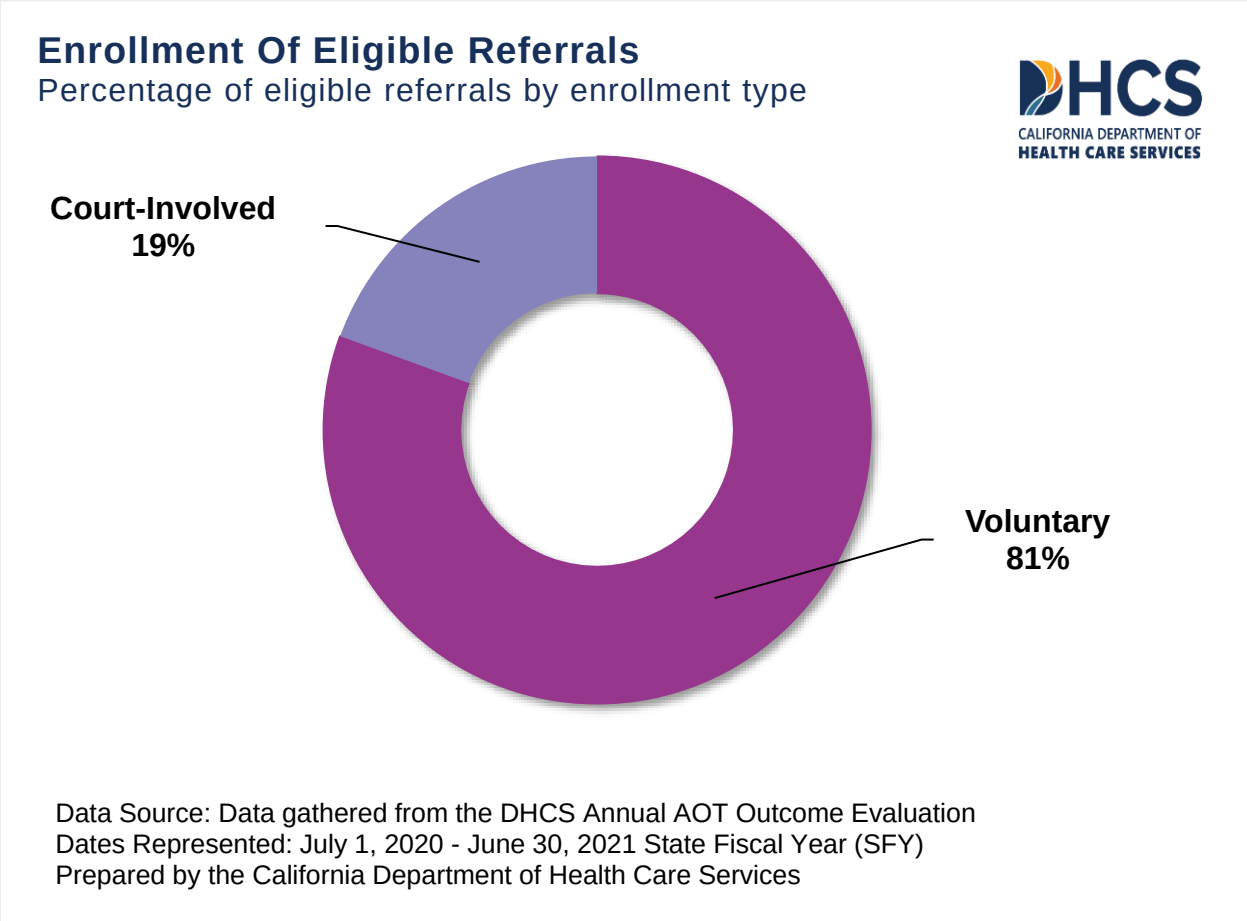


Table 3. Total AOT Referrals: Count of referrals by type

Enrollment Type	Count
Court-involved	197
Voluntary	817
Total	1,014

DHCS requests programmatic data from all AOT participating counties using a standardized data collection evaluation 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 initial outreach and collaboration with community partners, such as law enforcement and care providers, in order to locate referred individuals. The reported average length of time spent by programs on initial outreach was approximately 61 days. AOT outreach teams make it a priority to meet with clients in locations in which they feel most comfortable. Several counties emphasized the importance of increasing accessibility between the program, necessary support services and the client. Nine counties reported collaborating with various community resources to ensure clients had access to services such as medication, crises services, telehealth, and transportation. Kern County described meeting as many of the individual's tangible needs as possible (e.g., food, clothing, hygiene items) as well transportation to outpatient services whenever possible.

Counties also work to establish trust in order to encourage voluntary participation in services. Collectively, counties reported the average number of contact attempts (including phone, email, and in-person) made prior to escalating to court petition was approximately 22 per client. Counties have numerous methods for building relationships and establishing rapport with clients. Napa County's newly-implemented AOT program utilizes strength-based recovery, working with people "where they are at" philosophically and literally. Some counties reported that family engagement has been essential in aiding the client's recovery. Orange County hosts monthly family support meetings to provide psychoeducation and support to clients' loved ones. Testimonials by participants and their families consistently expressed appreciation for the perseverance and innovation of the outreach teams' efforts. Overall, these outreach and engagement efforts help to stabilize clients and encourage their participation in services.

Partnerships and Services

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 collaboratives and peer groups contributed to the robust access to resources for AOT participants.

Counties have also adopted strategies to provide support and treatment services in the field. Los Angeles County reported that their AOT team deployed a psychiatrist to respond to field visits to conduct evaluations and prescribe medication, if the client is willing, to support client stabilization. Orange County developed a new process to provide "Intentional Service Planning" through daily consultation with the treatment team and clinical supervisors to ensure the provision of quality care. The Intentional Service Planning has been supportive in providing regular consultation and feedback for addressing concerns and objectives with clients. Placer County coordinated with a

combination of programs, including local shelters, substance use treatment programs and sobering centers to meet treatment needs of their clients. Collectively, counties offer a myriad of services, both directly through the program and in collaboration with community programs, to meet the unique needs of AOT clients who have historically struggled with treatment engagement.

Figure shows the percentage of the 20 operational counties that offered services directly through the AOT program, and also the services that were linked or coordinated with other community-based programs.

Figure 2. Services Available for AOT Clients

Type of Service	AOT Program (Direct)	Community-Based (Linked)
Life Skills Support	95%	45%
Medication Management	95%	45%
Case Management	95%	50%
Crisis Intervention	95%	55%
Individual/Group Counseling	90%	50%
Housing Support	90%	75%
Transportation	85%	85%
SUD Treatment	80%	80%
Family/Relationship	75%	50%
Rehabilitation	70%	35%
Peer Support	70%	50%
Benefit Acquisition	70%	75%
Employment	65%	70%
Education	40%	60%
Diversion	30%	45%
Legal	20%	70%
Outreach Support	15%	45%
Restorative Justice	15%	45%
Medical	0%	5%

Number of counties = 20

Additionally, seven counties have reported assisting clients with obtaining financial benefits, such as Social Security Income/Social Security Disability Insurance and food assistance. Three counties assisted clients in obtaining vital records or documentation (e.g., identification, birth certificate, social security card).

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.

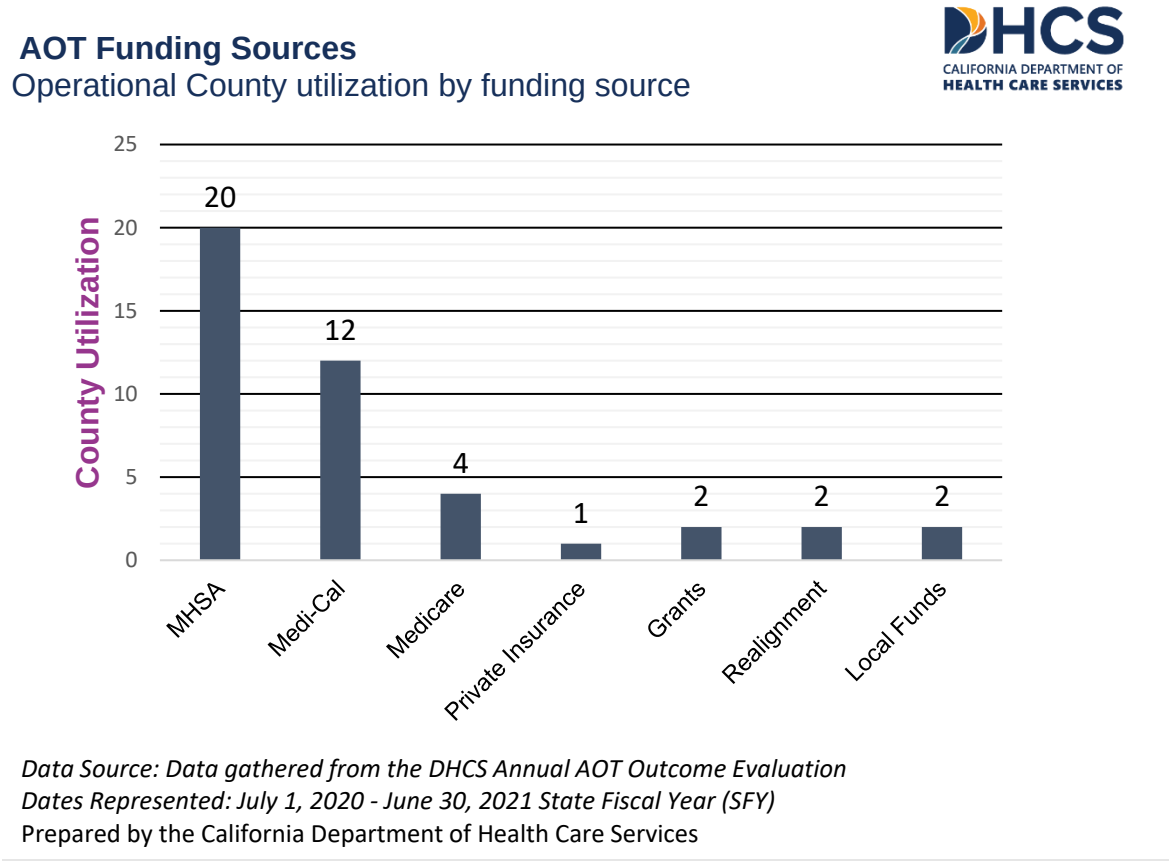
Seven counties provided survey data for this reporting period. Two counties received anonymous surveys for both AOT and Assertive Community Treatment[21] services, and thus could not determine results for individual AOT participants. The counties that did not receive surveys from participants reported that responses were limited due to COVID-19 or that satisfaction surveys are currently in development. In lieu of service satisfaction survey data, one county provided anonymous participant testimonials. Family members of AOT clients self-reported a positive impact or benefit for the client. Overall, the data available indicated participants feel confident in attaining treatment goals and program satisfaction 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, then utilizing Medi-Cal or other forms of health insurance once an individual receives placement at a provider. Other sources reported include local funds, realignment, and grants. See **Figure 3. Overview of AOT Funding Sources**, for information on 20 operational counties that utilized various funding sources.

[21] Assertive Community Treatment is an evidence-based mental health service delivery model for individuals with severe mental illness and is widely considered complementary to AOT services.

Figure 3. Overview of AOT Funding Sources



Data Source: Data gathered from the DHCS Annual AOT Outcome Evaluation
Dates Represented: July 1, 2020 - June 30, 2021 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 have resulted in significant cost savings, such as decreased involvement with the criminal justice system, including reduced interactions with law enforcement, and reduced frequency and duration of incarceration. Contra Costa County stated that they saw fewer court-involved clients experience jail bookings and hospitalizations during AOT enrollment compared to pre-enrollment, which can be associated with decreased costs for the county. Another area of significant cost reduction was the use of crisis interventions to avoid hospitalizations. Counties reported utilizing various intervention methods, including crisis call-in lines, crisis mobile teams, assessment and evaluations, and 24/7 on-call access to crisis teams. For the reporting period, all counties offered crisis call-in lines, and 9 of the 11 counties that reported court-involved client data deployed crisis mobile teams as intervention methods to serve AOT clients. These efforts will lead to longer-term cost savings for counties, by improving clients' stabilization and reducing their need for service utilization in the future.

Ongoing COVID-19 Impacts

As a result of the COVID-19 public health emergency, physical and behavioral health issues have increased. The Centers 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),*[22] "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 evaluation questions related to COVID-19 vaccinations, service delivery modifications, and new housing programs. The largest programmatic impacts due to COVID-19 were court closures and limited access to AOT clients and/or referred individuals. Additionally, visitation to jails and hospitals were restricted, limiting the ability of staff to engage with referred individuals. Sixteen counties made COVID-19 vaccinations accessible in some way for clients through their AOT program. While some counties provided transportation or coordinated appointments, many counties set up vaccination clinics and made a concerted effort to ensure that both enrolled and referred clients had access to vaccinations when they became available.

Despite the many challenges, all counties maintained treatment services during this time, and were resourceful in continuing to serve 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. Contra Costa County reported the program successfully continued to operate and engage clients in services throughout COVID-19-related closures by providing virtual access to court and saw improvements in court attendance among AOT clients during the reporting period. An additional challenge was the lack of available housing resources. Some counties

[22] The Impact of COVID-19 on Individuals with Serious Mental Illness

coordinated with Project Roomkey[23] or Homekey;[24] as a result, 21 AOT clients found shelter through these programs. Overall, counties were able to 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 W&I Code section 5348(d). Statute does not require counties or DHCS to evaluate data on voluntary participants. One hundred ninety-seven participants were served within the following 11 counties by court order or court settlement: Alameda, Contra Costa, Kern, Los Angeles, Mendocino, Nevada, Orange, Placer, San Diego, San Francisco, and Ventura.

The following outcomes are organized by the required data elements, with demographic information listed first.

Demographic Information

Each county provided demographic information on the 197 AOT court-involved individuals. In addition to the court process, age, gender, race/ethnicity and language categories, counties provided data on client insurance coverage and requisite criteria necessary for client enrollment; this data can be found in Chart 4 and Figure . See Appendix B for information on the AOT requisite criteria.

[23] 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

[24] Homekey continues a statewide effort to sustain and rapidly expand housing for persons experiencing homelessness or at risk of homelessness, and who are, thereby, inherently impacted by COVID-19 and other communicable diseases. For more information on Homekey, visit https://www.hcd.ca.gov/grants-and-funding/homekey

Table 4. Demographics - AOT Court-Involved Individuals for SFY July 1, 2020 – June 30, 2021[25]

Client Demographics	Total	% of Total
Court Process Type		
Court Order	106	54%
Court Settled	91	46%
Total	**197**	**100%**
Sex/Gender		
Female	67	34%
Male	105	53%
Other[26]	25	13%
Total	**197**	**100%**
Age Categories		
18-25	27	14%
26-49	133	68%
50+	37	18%
Total	**197**	**100%**
Race		
White or Caucasian	78	40%
Black or African American	37	19%
Hispanic or Latino	46	23%
Asian or Asian American	21	11%
Other, Multi race, or Not Reported	15	7%
Total	**197**	**100%**
Ethnicity		
Hispanic or Latino	45	23%
Not Hispanic or Latino	51	26%
Unknown/Not Reported	101	51%
Total	**197**	**100%**

[25] Percentages are derived from 197 total court-involved participants.
[26] "Other" can include transgender, non-binary, or not reported, which are aggregated to protect the confidentiality of individuals in this category.

Chart 4. Demographics - Insurance Type of AOT Court-Involved Client for SFY July 1, 2020 – June 30, 2021

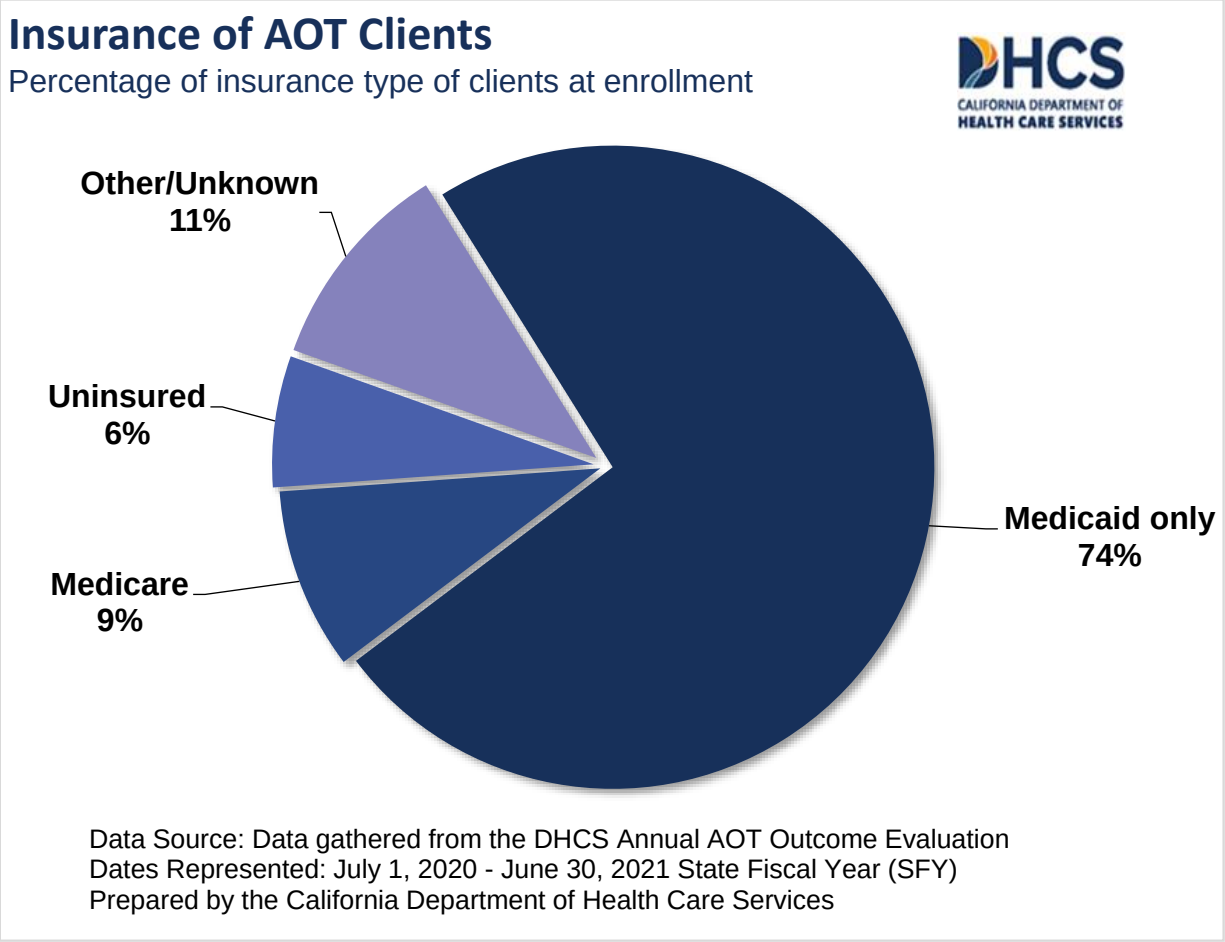


Table 5. Total Enrolled Client: Count by Insurance Type

Insurance Type	Count
Medicaid only	145
Medicare	18
Uninsured	13
Other[27]	21

[27] "Other" can include Medicare and Medicaid dually-eligible, commercially insured, or unknown/not reported, which are aggregated to protect the confidentiality of individuals in this category.

Figure 4. Demographics - Percentage of Court-Involved Clients that Met Requisite Criteria for SFY July 1, 2020 – June 30, 2021

In view of treatment history and current behavior, there has been a clinical determination that:

92%	Are unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating
89%	Are in need of AOT in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or to other

Mental illness has, at least twice within the last 36 months, been a substantial factor in:

80%	Necessitating hospitalization
12%	Receiving services in a forensic or other mental health unit of a correctional facility

Mental illness has, within the last 48 months:

66%	Resulted in one or more acts of serious and violent behavior toward themselves or another, or threats, or attempts to cause serious physical harm to themselves or another

While enrolled in AOT, were determined to need a higher level of care:

8%	Resulted in Lanterman-Petris-Short (LPS) Conservatorship placement

Table 6. Total Clients that Met Criteria: Count by factor type[28]

Criterion Type	Count
Substantially deteriorating	182
Grave disability or serious harm	175
Necessitating hospitalization	157
Services in mental health unit of a correctional facility	23
One or more acts of serious violent behavior	131
Resulted in Lanterman-Petris-Short (LPS) Conservatorship placement	16

Homelessness/Housing

Homelessness among participating clients was reduced by 26 percent during AOT enrollment, as compared to before program participation. This was a significant reduction, with a 38 percent 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. Alameda, Contra Costa, Kern, Los Angeles, Mendocino, Nevada, and Ventura counties all had a decline in homelessness among clients once enrolled into AOT. Placer and San Diego counties reported that all participants avoided homelessness while receiving AOT services.

Hospitalization

Hospitalizations were reduced by 51 percent during AOT enrollment, as compared to before program participation. Ten of the 11 counties reported a decrease in the number of days participants were hospitalized and in the frequency of psychiatric hospitalization. Additionally, six counties reported an over 50 percent reduction in hospitalizations among court-involved participants. In total, hospitalization days were reduced by 693 days for all counties.

Law Enforcement Contacts

Law enforcement contacts were reduced by 70 percent during AOT enrollment, as compared to before program participation. Alameda, Contra Costa, Los Angeles, and Orange counties saw a significant reduction in law enforcement contact. Collectively, eight counties reported the number of incarceration or jail days were reduced by 2,180 days.

[28] Data contains duplication as counties report clients can meet one or more of these categories.

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 37 percent of court-involved participants adhered to their treatment plans, and 67 percent maintained contact with their program. A reported 30 percent of court ordered participants entered treatment voluntarily when re-petitioned and 37 percent completed court-mandated treatment. All counties reported one or more of the following indicators of successful engagement: increased participation in treatment, established supportive relationships with providers, 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. Seven counties reported that court-involved individuals participated in educational and/or employment services during the reporting period. 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 résumé writing classes. Los Angeles County reported several clients found employment specifically in janitorial services, aerospace industry, and social service fields. Counties reported a 78 percent increase of gainful employment for participants during AOT enrollment, as compared to before program participation.

AOT programs may additionally offer or refer participants to educational services (e.g., general education development assistance). Counties reported a 67 percent increase of participant engagement in education services during AOT enrollment compared to before program participation. Both Contra Costa and Orange counties reported that AOT participants, with the support of vocational/education specialists, were successful in enrollment and taking college courses during AOT enrollment.

Victimization

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

victimization was reduced by 67 percent during AOT enrollment, 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. Alameda and Contra Costa counties reported a significant decrease in violent behavior. The provided data indicated a decrease in violent behavior by 80 percent during AOT enrollment, 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. 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 29 percent for court-involved individuals during AOT enrollment. Some counties reported successful substance use disorder 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 average number of service contacts with court-involved participants was two and half per week, for approximately 60 minutes per contact during this reporting period, and the average length of time of AOT enrollment was 287 days.

Enforcement Mechanisms

Enforcement mechanisms to encourage and ensure treatment plan compliance may include, but are not limited to, increased number of update hearings, increased case management, and increased intensity of treatment, additional mental health evaluations, and medication outreach/monitoring. Seven of the 11 counties that served court-involved participants reported utilizing enforcement mechanisms.[29] Contra Costa and Placer counties reported the use of all mechanisms for all court-involved participants during AOT enrollment.

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

Social Functioning

Examples of social functioning include the ability to interact positively with staff, participation in extracurricular activities, and building peer relationships. Nine out of 11 counties provided data on social functioning prior to and during AOT participation.[30] Of these, seven counties reported that compared to the time of enrollment, there was an overall improvement of 53 percent through the initial 180 days of enrollment and a 54 percent improvement at the time of discharge of court-involved 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, 10 of 11 counties provided data on independent living skills at AOT enrollment.[31] Of these, four counties reported that compared to at the time of enrollment, 31 percent of court-involved participants demonstrated an improvement through the initial 180 days of enrollment and 38 percent demonstrated an improvement at the time of discharge.

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

[30] As outlined in W&I Code section 5348(d), counties must provide data on required elements, if available. Social functioning data was not available for two counties.
[31] As outlined in W&I Code section 5348(d), counties must provide data on required elements, if available. Independent living skills data was not available for one county.

individuals 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. Therefore, there is potential for duplication of the collected data for the AOT program. However, DHCS continues to conduct an annual evaluation of the collection tools and make enhancements, where appropriate, to further address these limitations. Despite these limitations, DHCS' analysis suggests overall improved outcomes for AOT program participants and an increase in voluntary participation.

Conclusion

The aggregate outcomes of the 197 court-involved individuals, served across 11 counties, indicated success in reducing homelessness, hospitalizations, and involvement with law enforcement for the July 1, 2020 – June 30, 2021 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 (SB 677, Short, Chapter 1667, Statutes of 1967) created specific criteria by which an individual could be committed involuntarily to a locked inpatient facility for an assessment, in order to eliminate arbitrary hospitalizations. To meet LPS criteria, individuals must be a danger to themselves or others, or gravely disabled due to a mental illness (i.e., unable to care for daily needs). Following LPS, several state hospitals closed in 1973 to reduce the numbers of individuals housed in hospitals. The intention was to have communities provide mental health treatment and support to these discharged patients. However, due to limited funding, counties were unable to secure the resources necessary to provide adequate treatment or services. As a result, many of the individuals released from the hospitals became homeless or imprisoned with very little or no mental health treatment.

In 1999, the state of New York passed Kendra's law[32], 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." New York requires the program to be implemented in all counties and gives priority services to court-ordered individuals. Patterned after Kendra's Law, California passed Laura's Law (AB 1421, Thomson, Chapter 1017, Statutes of 2002).

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

[32] 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, a person must be referred by a qualified requestor and meet the defined criteria:

- The person is 18 years of age or older.
- The person is suffering from a mental illness.
- There has been a clinical determination that, in view of the person's treatment history and current behavior, at least one of the following is true:
    - The person is unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating.
    - The person is in need of 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 their mental illness, as demonstrated by at least one of the following:
    - At least two hospitalizations within the last 36 months, including mental health services in a forensic environment.
    - One or more acts of serious and violent behavior toward themselves or another, or threats, or attempts to cause serious physical harm to themselves or another within the last 48 months.
- The person has been offered an opportunity to participate in a treatment plan by the director of the local mental health department, or their designee, provided 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 there must be an option for a court settlement process rather than a hearing that would result in a court order.