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

**For the Reporting Period**
**July 1, 2021 – June 30, 2022**

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

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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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# Executive Summary

Assembly Bill (AB) 1421 (Thomson, Chapter 1017, Statutes of 2002) established the Assisted Outpatient Treatment (AOT) Demonstration Project Act of 2002 in Welfare and Institutions (W&I) Code sections 5345 – 5349.1, known as Laura's Law. Provisions of Laura's Law require the Department of Health Care Services (DHCS) to collect data outcomes from counties that have implemented[1] the AOT program, and 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 participants' clients'[2] risk for homelessness, hospitalizations, and involvement with local law enforcement.

This report provides statewide programmatic updates and aggregate outcomes[3] for 186 individuals from 14 counties that reported court-involved[4] participant data to DHCS for State Fiscal Year (SFY) July 1, 2021 – June 30, 2022. The 14 counties are Alameda, Contra Costa, Humboldt, Kern, Los Angeles, Mendocino, Napa, Nevada, Orange, Placer, San Diego, San Francisco, Tulare, and Ventura.

[1] "Implemented" refers to those counties that have opted-in to AOT and are in various stages of planning and development. Operational counties are those programs that are accepting AOT referrals and providing services.
[2] "Participant" refers to an individual who is enrolled in AOT program.
[3] "Aggregate outcomes" include available data for each element reported by counties.
[4] "Court-involved" refers to the participants 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

The AOT program showed high voluntary participation – 80 percent[5] of eligible individuals responded to the initial invitation for voluntary services and did not require a court petition or process. Aggregate outcomes indicated a positive impact of the primary objectives mandated by the statute governing AOT – homelessness, hospitalizations, and contact with law enforcement. Please reference Appendix C for outcome definitions.

## Key Outcomes

- ▼ Homelessness decreased by 16 percent.
- ▼ Hospitalization decreased by 52 percent.
- ▼ Contact with law enforcement decreased by 41 percent.
- \+ Forty percent of participants were able to secure employment or participated in employment and/or educational services.
- ▼ Victimization decreased by 60 percent.
- ▼ Violent behavior decreased by 61 percent.
- ▼ Substance use[6] was reduced by 30 percent.
- \+ Counties that provided data on social functioning reported improvements by 82 percent amongst participants at the time of court discharge.

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

# Background

AB 1421 (Thomson, Chapter 1017, Statutes of 2002) established the AOT Demonstration Project Act of 2002, known as Laura's Law. AOT provides court-ordered community treatment for individuals with a history of hospitalization and contact with law enforcement. Laura's Law is named after a woman who was one of three people killed in Nevada County by an individual with a diagnosed mental illness who was not following his prescribed mental health treatment. The legislation established an option for counties to utilize courts, probation, and mental health systems to address the needs of individuals unable to participate in community mental health treatment programs without supervision. See Appendix B for information on the AOT criteria and referral process. In 2008, the first AOT program was implemented in Nevada County. In 2012, program oversight was transferred from the former Department of Mental Health to DHCS and was incorporated into DHCS' county mental health performance contracts[7] with the enactment of Senate Bill (SB) 1009 (Committee on Budget and Fiscal Review, Chapter 34, Statutes of 2012). AB 1569 (Allen, Chapter 441, Statutes of 2012) extended the sunset date for the AOT statute from January 1, 2013, to January 1, 2017.

The statute allowed counties to elect to provide AOT services; however, it did not appropriate additional funding to counties for this purpose. Nevada County operated the only AOT program until the passage of SB 585 (Steinberg, Chapter 288, Statutes of 2013), which authorized the use of Mental Health Services Act (MHSA)[8] funds for Laura's Law services, as described in W&I Code sections 5347 and 5348. 19 counties implemented AOT following the enactment of SB 585. The sunset date was then extended until January 1, 2022, with the enactment of AB 59 (Waldron, Chapter 251, Statutes of 2016).

AB 1976 (Eggman, Chapter 140, Statutes of 2020) required all California counties to offer AOT services, either independently or in a partnership with neighboring counties, unless the county elects to opt out in specified ways. AB 1976 repealed the sunset date of Laura's Law, extending the program indefinitely. Additionally, AB 1976 added a superior court judge as an eligible petitioner for AOT services to be filed for a person who appears before the judge.

SB 507 (Eggman, Chapter 426, Statutes of 2021) broadened the criteria to permit AOT for a person who needs such services, without also requiring that the person's condition be substantially deteriorating. This bill additionally required the examining mental health

[7] DHCS county mental health performance contracts became effective July 2013.
[8] 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, significant mental health needs, and their families.

professional, in their affidavit to the court, to determine if the subject of the AOT petition has the capacity to give informed consent regarding psychotropic medication.

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

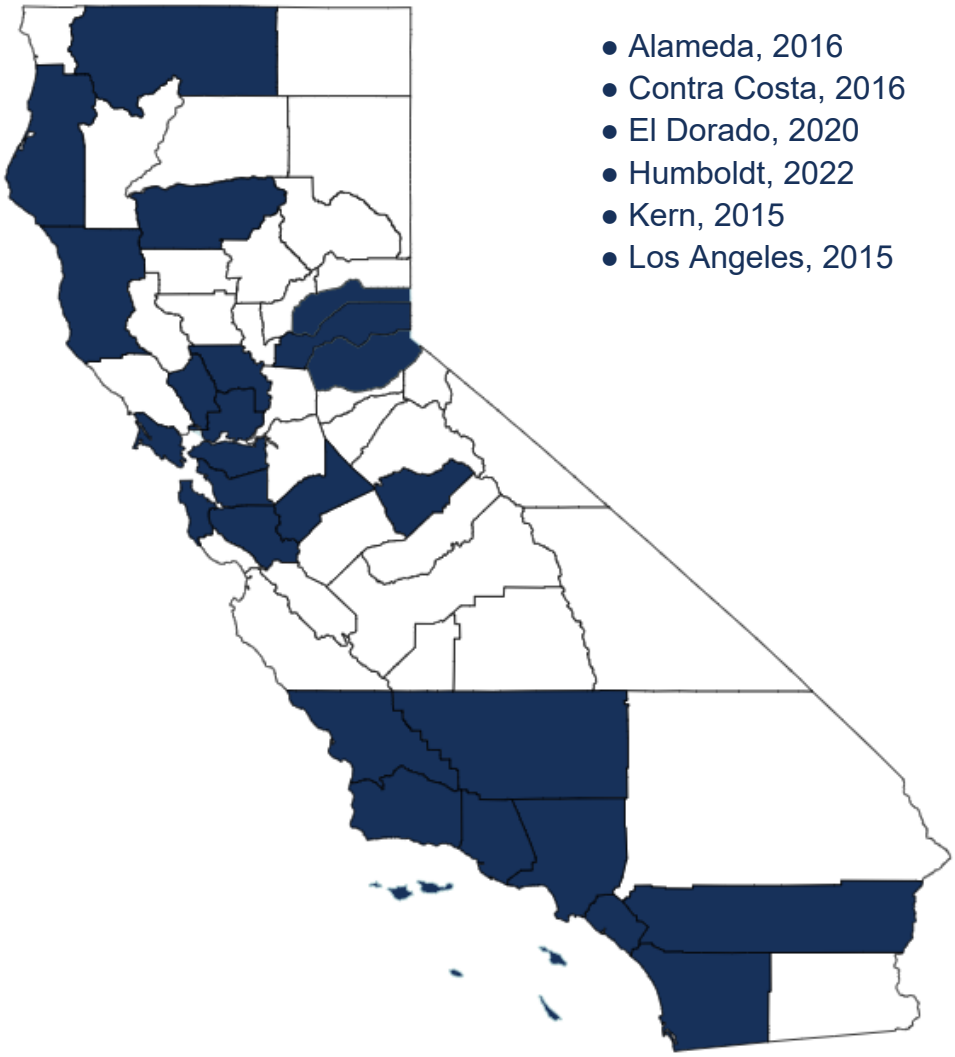
To the extent data is provided by participating counties, DHCS must also report on the following:

- adherence to prescribed treatment;
- participation in employment and/or education services;
- victimization;
- incidents of violent behavior;
- substance use;
- type, intensity, and frequency of treatment;
- other indicators of successful engagement;
- enforcement mechanisms;
- level of social functioning;
- independent living skills; and
- satisfaction with program services.

## AOT Implementation and Operational Status[9]

31 of the 58 counties were implemented during the SFY July 1, 2021 – June 30, 2022. 27 of those counties were operational and serving AOT participants during the reporting period as shown in Figure 1.

Figure 1. Counties and Operational Year



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

[9] Prior reports reflected the county implementation and operational status at the time of the AOT Outcome Evaluation submission.

## 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 participants from some or all of the following sources:[10]

- Participant intake information;
- MHSA FSP Outcome Evaluation forms including:
  - Partnership Assessment Form – the FSP baseline intake assessment;
  - Key Event Tracking (KET) – tracks changes in key life domains, such as employment, education, and living situation;
  - Quarterly Assessment – tracks the overall status of 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);[11] 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 to address continued data limitations (i.e., referral data) and further standardize the data collection process. As a result, DHCS issued Behavioral Health Information Notice: 22-035, which provides guidance on AOT implementation and reporting requirements, including the Data Dictionary and Outcome Evaluation.

15 months following the close of each SFY, DHCS receives AOT data from implemented counties. DHCS then conducts a preliminary review for completeness and accuracy of the data received. Following finalization of the data, DHCS completes its

[10] 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.
[11] 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 align evaluations of participant progress more closely 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.

analysis and develops the annual report. Due to the lag associated with receiving, cleaning, and analyzing AOT data, the annual AOT report is published approximately 22 months following the close of the reporting period covered by the report.

Due to the small and distinct AOT population data reported, participants may be identifiable. DHCS is committed to complying with federal and state laws pertaining to health information privacy and security[12]. To protect participants' health information and privacy rights, some numbers for each of the specified outcomes cannot be publicly reported. For DHCS to satisfy its AOT program evaluation reporting requirement, as well as protect individuals' health information, DHCS adopted standards[13] and procedures to appropriately and accurately aggregate data, as necessary. DHCS aggregates are dependent upon total participants experiencing each data element. All averages are weighted,[14] and overall totals vary.

[12] 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.
[13] The DHCS Data De-identification Guidelines (DDG) V2.2 is based on the California Health & Human Services Agency DDG, which is focused on the assessment of aggregate or summary data for purposes of de-identification and public release. For additional information and to view DDG, see the Public Reporting Guidelines on DHCS' webpage.
[14] All averages are weighted throughout this report unless otherwise indicated.

# Findings for SFY July 1, 2021 – June 30, 2022

## Statewide Findings

In addition to the measures specified in W&I Code section 5348, DHCS requests programmatic information from all AOT implemented counties. The following sections provide a comprehensive overview of the strategies employed and data outcomes during the SFY 2021-2022 reporting period.

### Referrals and Enrollment

Laura's Law authorizes specified persons or entities[15] to request county mental health departments to investigate the appropriateness of filing an AOT petition. During this reporting period, 1,947 individuals were referred to AOT services across 25 of the 27 operational counties[16]. As shown in Table 1 (below), 930 individuals (48 percent) were found eligible for AOT, and 537 individuals (27 percent) were found to be ineligible.

Loss of contact with individuals who are the subject of an AOT petition is often attributed to individuals leaving a county once notified of the investigation. Counties reported that some individuals were eventually located and reengaged in services. Overall, 235 individuals (12 percent) were unable to be located during this reporting period.

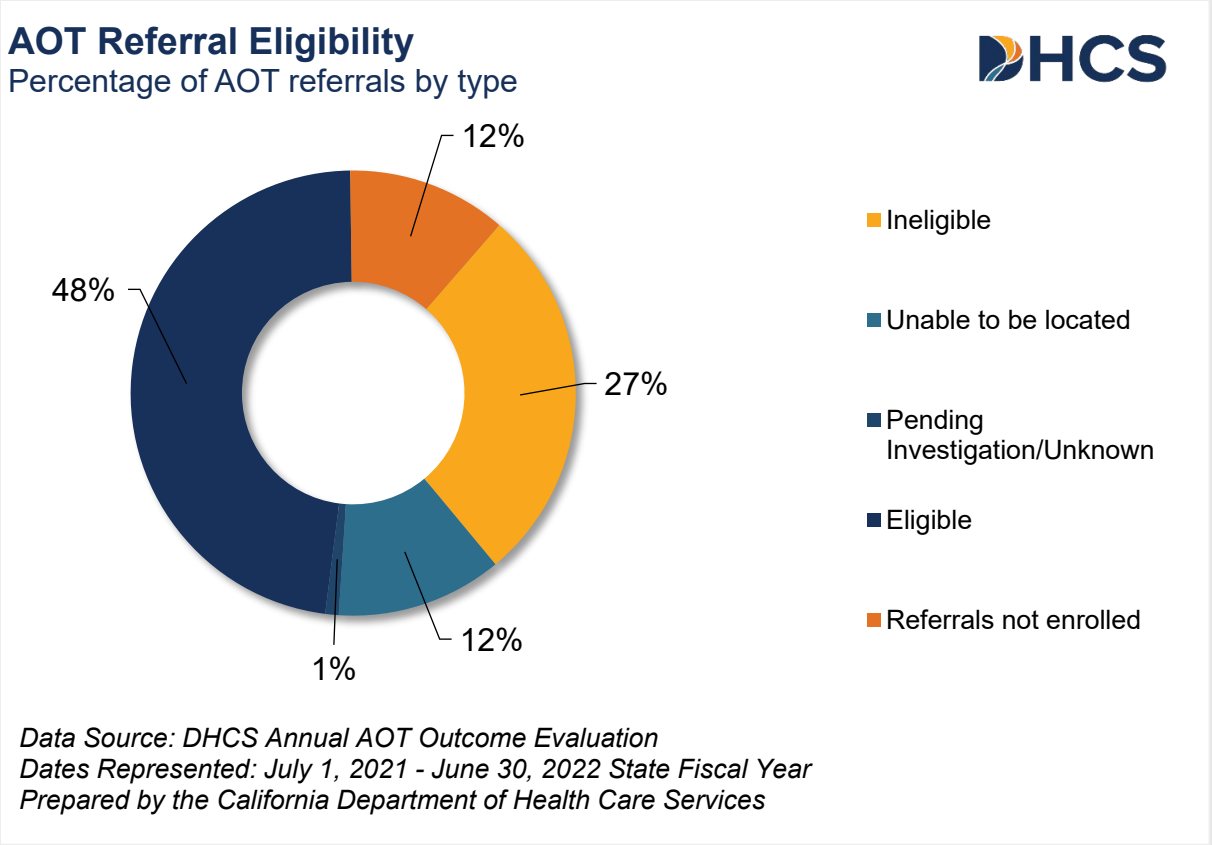
[15] W&I Code section 5346, subd. (b)(2)

[16] Tehama and Siskiyou are operational but did not receive any AOT referrals during this reporting period.

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

| Referrals | Count |
|---|---|
| Eligible | 930 |
| Ineligible | 537 |
| Unable to be located | 235 |
| Referrals not Enrolled[17] | 226 |
| Pending Investigation/Unknown[18] | 19 |
| Total | 1,947 |

## Chart 1. Overview of Statewide Referral Eligibility




[17] Referred individuals who were not enrolled into AOT services may or may not have been determined to meet AOT eligibility criteria.

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

As shown in Table 1 (above), a total of 226 (12 percent) referred individuals were not enrolled in AOT during this reporting period. Most of these individuals were not enrolled due to incarceration, Lanterman-Petris-Short Act (LPS) [19] conservatorship, or diversion, as shown in Table 2 (below). Notably, some referred individuals were deemed ineligible after initial contact with AOT teams and were connected with alternative behavioral health treatment or short-term case management services.

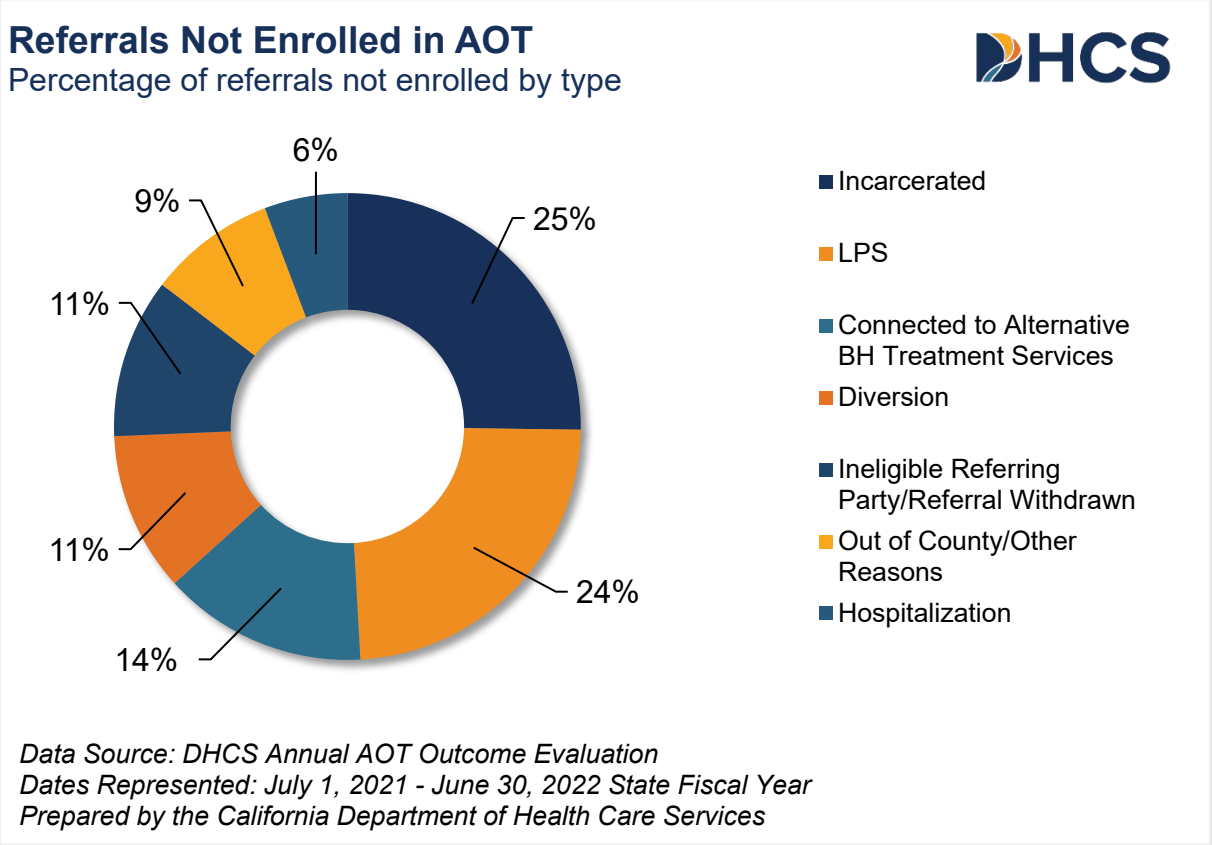
## Table 2. Referrals Not Enrolled: Count of referrals per category

| Referrals Not Enrolled | Count |
|---|---|
| Incarcerated | 57 |
| LPS | 54 |
| Connected to Alternative BH Treatment | 32 |
| Diversion | 25 |
| Ineligible Referring Party/Referral Withdrawn | 25 |
| Out of County or Other Reason[20] | 20 |
| Hospitalization | 13 |
| Total | 226 |

[19] For information on LPS refer to Appendix A.

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

## Chart 2. Overview of Statewide Referrals Not Enrolled

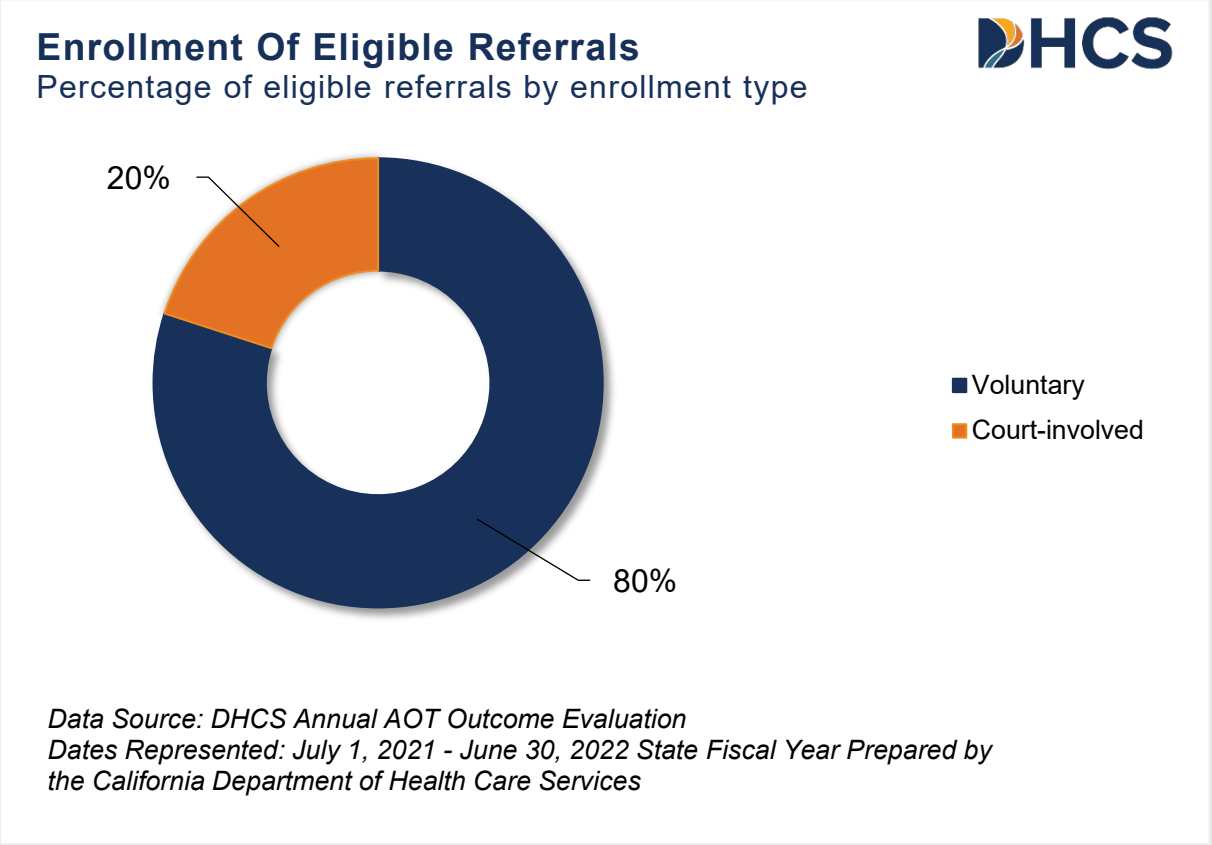



As shown in Table 3 (below), 744 referred individuals (80 percent) that were determined to meet eligibility accepted voluntary services and did not require a court petition. Overall, 20 percent of eligible referrals received entered AOT as a result of court orders or settlements.

## Table 3. Total Eligible Referrals: Count of Enrollment by type

| Enrollment Type | Count |
|---|---|
| Voluntary | 744 |
| Court-involved | 186 |
| Total | 930 |

Chart 3. Overview of Statewide Enrollment of Eligible Referrals




## Methods of Outreach and Engagement

AOT programs have a well-established and comprehensive approach to outreach and engagement. Many counties reported initial outreach as a critical component to locate referred individuals, which is often conducted in collaboration with community partners such as law enforcement, family members, and care providers. Once located, outreach teams promptly triage referred individuals to determine needs, deliver in-field services, and provide connections to appropriate resources. Counties prioritize building rapport to encourage voluntary participation, including outreach teams meeting in a location where the individual feels most comfortable to establish trust. The average duration of county outreach and engagement efforts, prior to filing an AOT petition, was 52 days and at least 12 contact attempts via phone, email, and/or in-person during this reporting period.

County outreach and engagement efforts extend beyond referred individuals and enrolled AOT participants. Counties report that family engagement is essential in aiding the participant's recovery. For example, Orange County continues to host monthly

family support meetings and offer Family Psychoeducation[21] to support participants' loved ones. Kern County provides ongoing community presentations to educate families and the general public on Laura's Law and available AOT services. In Riverside County, Family Advocates are connected with family members and/or friends to provide support and offer resources to help with understanding the AOT process as well as educating them on methods to support the AOT participant during this time.

## Partnerships and Services

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

[21] Family Psychoeducation is a method for training families to work together with mental health professionals as part of a team to help family members with psychiatric disorders recover and maintain psychological health.

## Table 4. Community-Based Services[22]

| Community-Based Services | | |
|---|---|---|
| **Service Type** | **Number of Counties** | **Percentage** |
| Housing support | 24 | 89% |
| Substance use disorder treatment | 23 | 85% |
| Education | 20 | 74% |
| Employment | 19 | 70% |
| Crisis intervention | 18 | 67% |
| Transportation | 17 | 63% |
| Legal | 17 | 63% |
| Outreach support | 17 | 63% |
| Case management | 16 | 59% |
| Benefit Acquisition | 17 | 59% |
| Individual/group counseling | 16 | 59% |
| Medication management | 15 | 56% |
| Peer Support | 14 | 52% |
| Life skills support | 13 | 48% |
| Family/Relationship | 12 | 44% |
| Diversion | 12 | 44% |
| Rehabilitation | 11 | 41% |
| Restorative Justice | 10 | 37% |

## Service Satisfaction

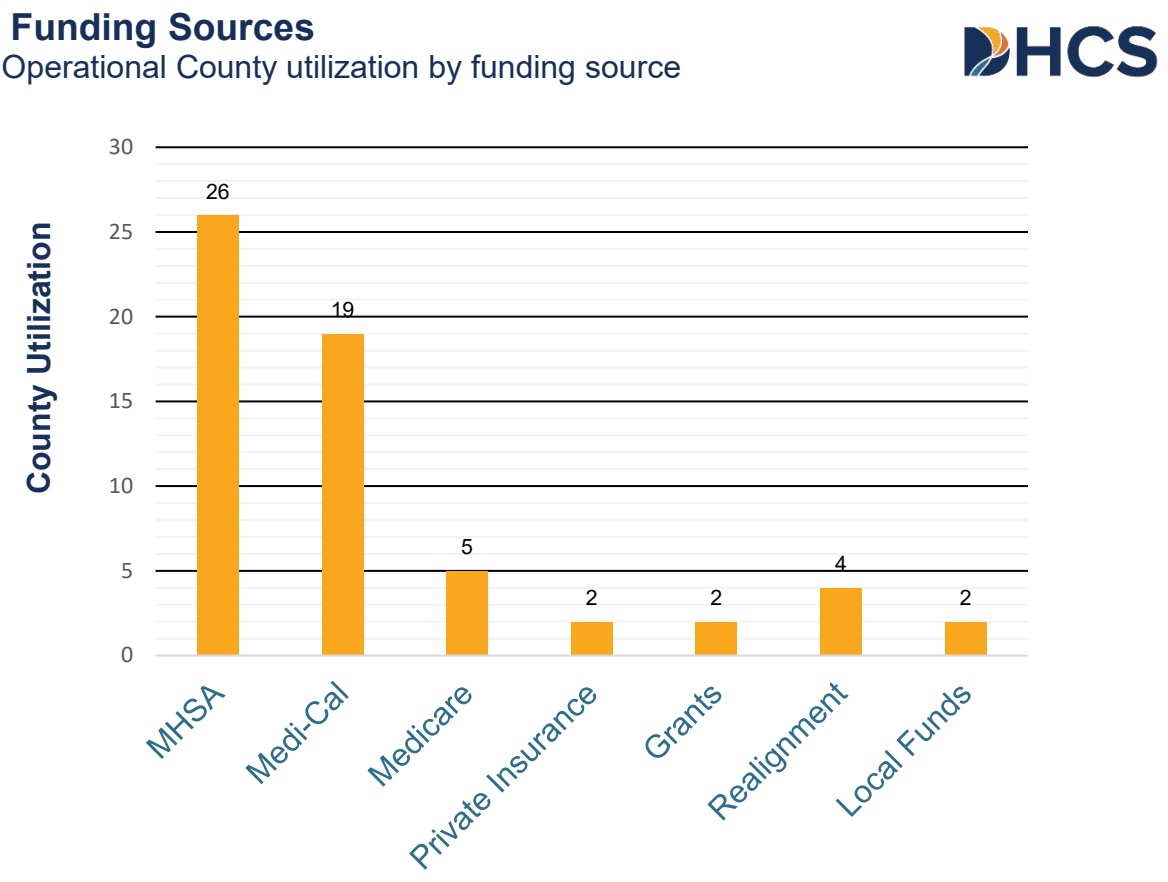
Pursuant to W&I Code Section 5348(d)(14), DHCS is required to report service satisfaction of participants and/or their families based on available county data. DHCS encourages counties to develop and issue consistent satisfaction surveys to program participants and family members to solicit feedback and promote program adaptability. Six counties reported not having data to report regarding the satisfaction survey. The remaining 21 counties reported that satisfaction surveys are currently in development.

[22] Percentages are derived from 27 operational counties.

## Funding Sources

Most counties rely on multiple funding sources to support their AOT programs, with MHSA and Medi-Cal being the most commonly utilized. See Figure 3 (below), for an overview of the various funding sources utilized amongst the 27 operational counties.

### Figure 3. Overview of Funding Sources




*Data Source: DHCS Annual AOT Outcome Evaluation*
*Dates Represented: July 1, 2021 - June 30, 2022 State Fiscal Year*
*Prepared by the California Department of Health Care Services.*

## Areas of Significant Cost Reduction

Counties make considerable financial investments to address the comprehensive needs of the AOT population, and these investments have resulted in significant cost savings for some counties. Eight counties reported cost savings due to reduced hospital and criminal justice system utilization, and/or fewer emergency interventions. Los Angeles County reduction in hospitalizations resulted in a total cost savings of $288,000.

All counties reported utilizing various intervention methods, including crisis call-in lines, mobile crisis teams, assessment and evaluations, and 24/7 on-call access to crisis teams. Counties anticipate that these efforts will lead to long-term cost savings by improving participants' stabilization and reducing their need for service utilization in the future.

## COVID-19 Update

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

All AOT treatment services remained accessible during the COVID-19 public health emergency which occurred during this reporting period. Programs followed safety guidelines and used personal protective equipment, such as masks and gloves, to continue to meet with individuals face-to-face to the extent possible. Several counties indicated utilizing telehealth as an option to provide AOT services and engage with participants. Twenty-one counties made COVID-19 vaccinations accessible to AOT participants. While some counties provided transportation for coordinated appointments, others set up vaccination clinics at community health centers through county public health programs and made a concerted effort to ensure that both enrolled and referred participants had access to vaccinations.

Scarcity of available housing presented additional challenges during this reporting period. Placer, Ventura, Alameda, Humboldt, and Contra Costa County coordinated with Project Roomkey[23] or Homekey[24] to provide shelter to some AOT participants.

Overall, all counties navigated through the COVID-19 public health emergency challenges and continued their commitment to serving the AOT population.

[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

## Court-Involved Findings

DHCS collects specified data to evaluate the effectiveness of the strategies employed by each program operated for court-involved participants [25], as outlined in W&I Code section 5348(d). The following information is organized by the outcome measures of the required data elements, with court-involved participant enrollment information presented first.

### Court-Involved Participant Enrollment

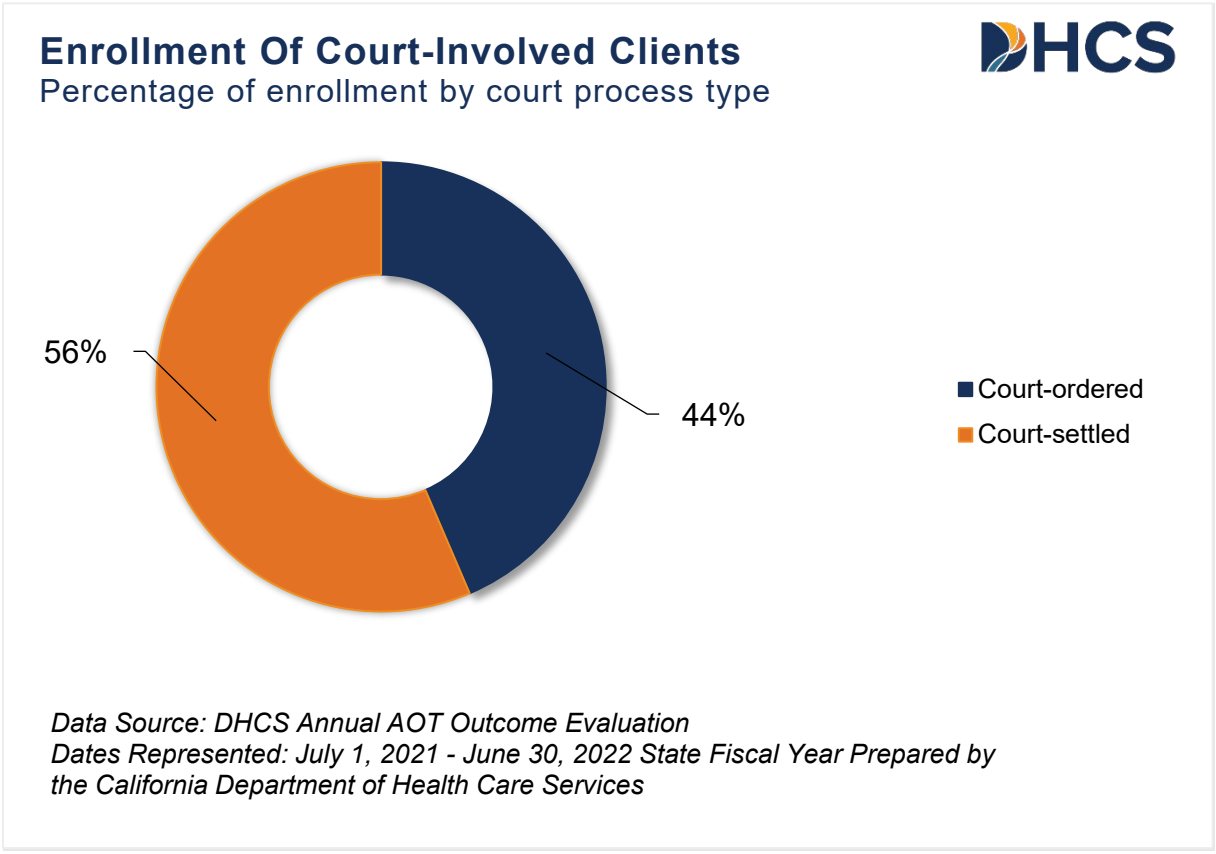
One hundred eighty-six participants were served within the following 14 counties by court-order or court-settlement: Alameda, Contra Costa, Humboldt, Kern, Los Angeles, Mendocino, Nevada, Orange, Placer, San Diego, San Francisco, San Mateo, Tulare, and Ventura.

#### Table 5. Enrollment: Total count by court process type

| Court Process Type | Count |
|---|---|
| Court-ordered | 105 |
| Court-settled | 81 |
| Total | 186 |

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

## Chart 4. Overview of Court-Involved Enrollment



## Demographic Information

### Table 6. Participant Demographics[28]

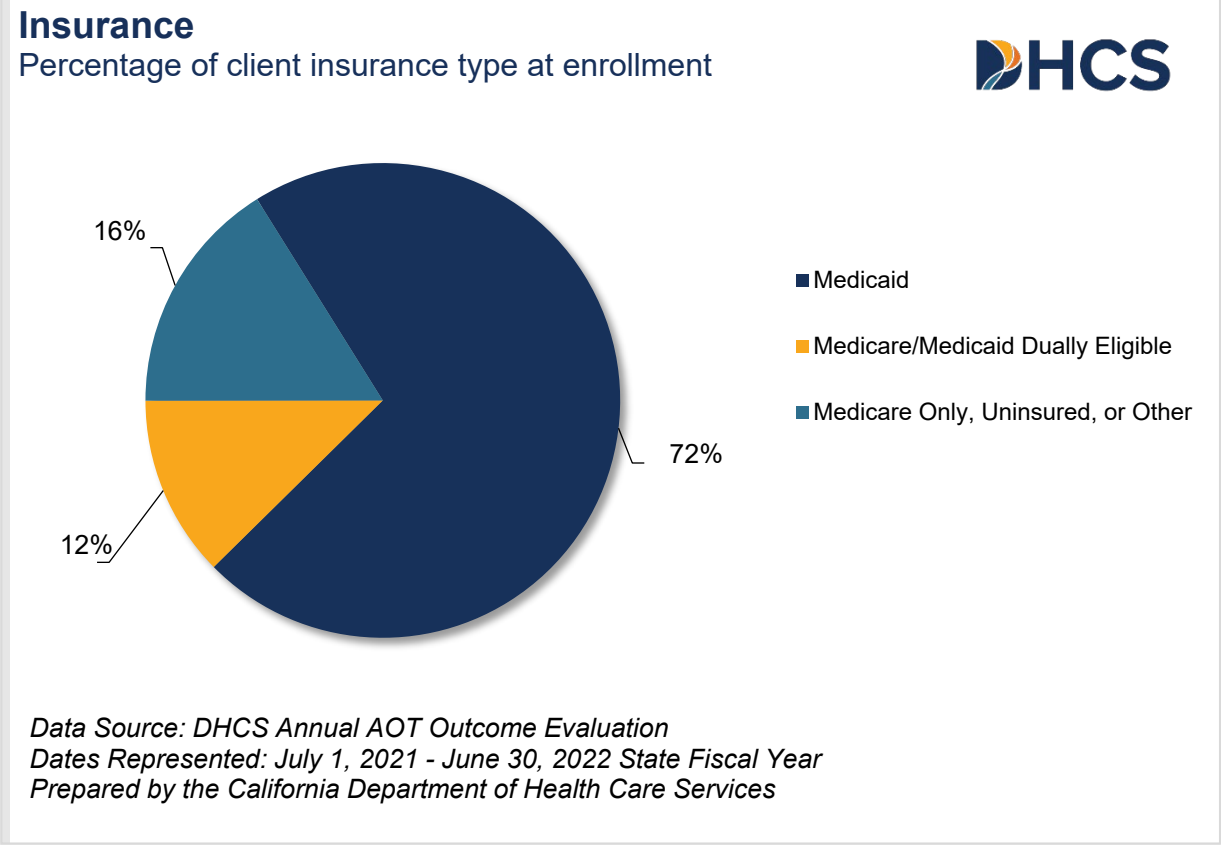
| Participant Demographics | Total | % of Total |
|---|---|---|
| Sex/Gender | | |
| Male | 123 | 66% |
| Female, Other, or Unknown/Not Reported[26] | 63 | 34% |
| Total | 186 | 100% |
| Age Categories | | |
| 18-25 | 15 | 8% |
| 26-49 | 134 | 72% |
| 50+ or Unknown/Not Reported[27] | 37 | 20% |
| Total | 186 | 100% |
| Race | | |
| White or Caucasian | 63 | 34% |
| Black or African American | 34 | 18% |
| Hispanic or Latino | 47 | 25% |
| Asian or Asian American | 23 | 12% |
| Multi-race, Other, or Unknown/Not Reported | 19 | 11% |
| Total | 186 | 100% |
| Ethnicity | | |
| Hispanic or Latino | 50 | 27% |
| Not Hispanic or Latino | 85 | 46% |
| Unknown/Not Reported | 51 | 27% |
| Total | 186 | 100% |

[26] "Other" can include transgender or non-binary and are aggregated to protect the confidentiality of individuals in this category.
[27] "Unknown/Not Reported" are aggregated to protect the confidentiality of individuals in this category.
[28] Percentages are derived from 186 court-involved participants.

## Table 7. Enrolled Participants: Count by Insurance Type

| Insurance Type | Count |
|---|---|
| Medicaid only | 133 |
| Medicare/Medicaid Dually Eligible | 23 |
| Medicare Only, Uninsured, or Commercially insured | 30 |
| Total | 186 |

## Chart 5. Demographics - Insurance Type




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

Every 60 days, counties are required to file an affidavit with the court to affirm participants continue to meet the requisite criteria. Figure 4 (below), provides an overview of some of the requisite criteria met by court-involved participants. See Appendix B for information on all requisite criteria.

## Figure 4. Demographics - Percentage of Participants that Met Requisite Criteria[29]

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

| | |
|---|---|
| **90%** | Are unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating |
| **57%** | 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:**

| | |
|---|---|
| **78%** | Necessitating hospitalization |
| **28%** | Receiving services in a forensic or other mental health unit of a correctional facility |

**Mental illness has, within the last 48 months:**

| | |
|---|---|
| **62%** | 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:**

| | |
|---|---|
| **5%** | Resulted in Lanterman-Petris-Short (LPS) Conservatorship placement |

## Outcomes

Each county reports participant pre-enrollment[30], during enrollment, and discharge data for court-involved participants, as available. These measures are used to evaluate and compare statewide outcomes of the following data elements over the course of the reporting period.

[29] Data contains duplication as participants may meet one or more of these categories.

[30] Pre-enrollment refers to data on participant activity or history prior to entering the AOT program. These data are captured up to 12 months prior to participants entering the program.

## Homelessness/Housing

Over 50 percent of participants were housed prior to AOT enrollment. 4 counties reported participants successfully obtained housing through the AOT program. 63 percent of participants maintained housing during AOT enrollment. Overall, the number of participants experiencing homelessness was reduced by sixteen percent during AOT enrollment, as compared to before program participation.

## Hospitalization

Hospitalizations were reduced by 52 percent during AOT enrollment, as compared to before program participation. Ten counties reported the use of crisis interventions to avoid hospitalizations through mobile crisis teams. 11 counties reported a decrease in frequency of psychiatric hospitalization. Additionally, seven counties reported over a 50 percent reduction in hospitalizations. In total, the days of hospitalization were reduced by 1,183 in the 11 counties that provided this data.

## Law Enforcement Contacts

Law enforcement contacts were reduced by 41 percent during AOT enrollment, as compared to before program participation. Mendocino, Napa, and San Diego reported that all participants avoided contact with law enforcement during AOT enrollment. Nevada and Orange County reported over 50 percent reduction in law enforcement contacts amongst enrolled participants. Collectively, the days of incarceration or jail were reduced by 838 days in the seven counties that provided this data.

## Treatment Participation/Engagement

Each county provided data on participants' adherence to treatment, whether they maintained contact with their program or not, 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 57 percent of court-involved participants adhered to their treatment plans, and 71 percent maintained contact with their program. A reported 42 percent of court-ordered participants entered treatment voluntarily when re-petitioned, and 58 percent completed court-mandated treatment. 13 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. Nine counties reported that court-involved participants participated in educational and/or employment services during the reporting period. Many counties 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. Counties reported a 44 percent increase of gainful employment for participants during AOT enrollment, as compared to before program participation.

## Victimization

Historically, counties have reported participants 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 60 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. The provided data indicated a decrease in violent behavior by 61 percent during AOT enrollment, as compared to before program participation.

## Substance Use

The majority of participants in AOT are living with co-occurring diagnoses, including mental illness with substance use disorder (SUD). Eight counties reported successful SUD treatment completion of enrolled participants. 11 counties regularly screen for substance use, which can assist in identifying when participants may need additional support and progress towards treatment goals. Overall, substance use was reduced by 30 percent for court-involved participants during AOT enrollment, as compared to before program participation.

## Type, Intensity, and Frequency

Counties work with local stakeholders during the initial stages of implementation to determine the type, intensity, and frequency standards of AOT treatment services. In

accordance with W&I Code section 5348, programs are required to provide participant-centered services that are gender, age, and culturally appropriate. Counties offer a full array of multidisciplinary services with varying frequencies and intensity. Collectively, the median number of service contacts with court-involved participants was three per week, for approximately 60 minutes per contact, and the average length of time of AOT enrollment was 287 days during this reporting period.

## Enforcement Mechanisms

Enforcement mechanisms used 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. 11 of the 14 counties that served court-involved participants reported utilizing enforcement mechanisms[31]. Four counties reported the use of all available enforcement mechanisms for some participants during AOT enrollment.

## Social Functioning

Counties may use assessments and/or collateral reports to determine a participant's social functioning[32]. All 14 counties reported that, compared to the time of enrollment, there was an overall improvement of 86 percent through the initial 180 days of enrollment, and an 82 percent improvement at the time of discharge of court-involved participants.

## Independent Living Skills

Independent living skills include stress management, food preparation, hygiene maintenance, and the ability to utilize transportation. 11 of the 14 counties provided data on independent living skills.[33] Of these, ten counties reported that compared to at the time of enrollment, 27 percent of court-involved participants demonstrated an improvement through the initial 180 days of enrollment, and 33 percent demonstrated an improvement at the time of discharge.

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[31] 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 three counties.

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

[33] 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 three counties.

## Limitations

The following limitations were identified in DHCS' analysis of the AOT program. The statewide total count of court-involved participants remains small and there is no comparison and/or control group; therefore, improvements cannot be exclusively linked to AOT program services. Some of the measures are based on self-reports and/or recollections of past events, which may or may not be accurate or reliable. Moreover, individuals enter AOT at varying times, resulting in carry-over data from prior reporting periods. DHCS requests the number of individuals 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 various 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 applicable, to further address these limitations. Despite these limitations, DHCS' analysis suggests overall improved outcomes for AOT program participants and an increase in voluntary participation.

## Discussion

The needs of the vulnerable population eligible for AOT are complex; thus, the strategies employed by counties to support whole-person wellness were uniquely designed to meet the full-spectrum of participants' treatment goals. Overall, counties demonstrated efforts to provide an equity-focused approach to ensure AOT participants received age, gender, and culturally appropriate services. Despite the continued challenges brought forth by the COVID-19 public health emergency, counties and providers continued to be of service amidst severe behavioral health workforce shortages. Throughout AOT programs, behavioral health staff connected participants with access to shelter, employment and educational training, medication, counseling, and additional resources to aid in recovery.

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

## Conclusion

This report provides comprehensive information on AOT program findings, including program successes and challenges, for the SFY 2021-22 reporting period. Despite the challenges, the AOT program has effectively addressed participants' needs. The ongoing commitment of the counties to provide integral services through collaborative efforts with community partners and innovative engagements strategies remains crucial to support the stabilization and recovery of the AOT participants. The aggregate outcomes of the 186 court-involved individuals indicated success in most outcome measures, including reductions in homelessness, hospitalizations, and involvement with law enforcement.

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

Among significant reforms in mental health care, the 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 to eliminate arbitrary hospitalizations. To meet LPS criteria, individuals must be a danger to themselves or others, or gravely disabled due to a mental illness (i.e., unable to care for daily needs). Following LPS, several state hospitals closed in 1973 to reduce the numbers of individuals housed in hospitals. The intention was to have communities provide mental health treatment and support to these discharged patients. However, due to limited funding, counties were unable to secure the resources necessary to provide adequate treatment or services. As a result, many of the individuals released from the hospitals became homeless or imprisoned with very little or no mental health treatment.

In 1999, the state of New York passed Kendra's law[34], after Kendra Webdale was pushed in front of a subway train. A man with a long history of severe mental instability and multiple short hospitalizations was responsible for her death. The law authorized court-ordered AOT for individuals with mental illness and a history of hospitalizations or violence. Additionally, this required participation in appropriate community-based services to meet their needs. Kendra's Law defines the target population to be served as, "…mentally ill people who are capable of living in the community without the help of family, friends and mental health professionals, but who, without routine care and treatment, may relapse and become violent or suicidal, or require hospitalization." New York requires the program to be implemented in all counties and gives priority services to court-ordered individuals. Patterned after Kendra's Law, California passed Laura's Law (AB 1421, Thomson, Chapter 1017, Statutes of 2002).

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

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

# Appendix B: Requisite AOT Criteria

Pursuant to W&I Code section 5346(a), in order to be eligible for AOT, a person must be referred by a qualified requestor and meet the defined criteria:

- The person is 18 years of age or older.
- The person is suffering from a mental illness.
- There has been a clinical determination that, in view of the person's treatment history and current behavior, at least one of the following is true:
    - The person is unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating.
    - The person is in need of 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 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.

# Appendix C – Glossary

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

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

**Employment:** A participant that is legally employed.

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

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

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

**Hospitalization:** A participant admitted to a health facility.

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

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

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

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

**Maintained Housing:** Participant did not experience one day (24 hours) homeless (as defined above) for the duration of receiving services through AOT program.

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

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

**Social Functioning**: A participant's interaction and ability to self-manage, without impact from symptoms of diagnoses, within environments including, but not limited to, community, treatment program, social activities, and relationships with support systems

**Substance Use:** A higher degree of use, whereby a participant continues to use alcohol or drugs despite the presence of negative impacts.

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

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

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