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LAURA'S LAW ASSISTED OUTPATIENT TREATMENT

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Assisted Outpatient Treatment Summary & Recommendations



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ASSISTED OUTPATIENT TREATMENT

INTRODUCTION

The mission of Stanislaus County Behavioral Health and Recovery Services (BHRS) is, in partnership with the community, to provide and manage effective prevention and behavioral health services that promote the community's capacity to achieve wellness, resilience, and recovery outcomes. BHRS provides a full range of mental health services to children, transitional age youth, adult, and older adult residents of Stanislaus County. The range of services provided in the BHRS continuum of care are intended to address the needs of individuals with specialty mental health needs, including those with Severe and Persistent Mental Illness (SPMI).

For these consumers with SPMI, a key challenge for Stanislaus County is reducing high utilization of hospital, crisis, and jail services through increased engagement with the consumers most in need of support. In their effort to identify possible methods to increase engagement and effective mental health care of these consumers, BHRS commissioned The Results Group to assess Assembly Bill 1421 and provide an independent and unbiased recommendation regarding its adoption in Stanislaus County.

AB 1421 – LAURA'S LAW

In 2002, California's State Assembly passed the Assisted Outpatient Treatment Demonstration Project Act (AB 1421), also known as Laura's Law, in response to the 2001 murder of three adults in Nevada County by an individual with untreated mental illness. The demonstration project authorized by AB 1421 was extended in 2016 via Assembly Bill 59 until 2022. The full text of AB 1421 and AB 59 can be found in Appendix A and B, respectively.

Laura's Law authorizes the provision of Assisted Outpatient Treatment (AOT) to eligible individuals on an involuntary basis via a process of court ordered intensive outpatient treatment. Referrals to AOT can be submitted by individuals with a relationship to the consumer, including family, friends, probation officers, or service providers. The key characteristics of AOT services are shown below in Table 1.

TABLE 1 - ASSISTED OUTPATIENT TREATMENT SERVICE CHARACTERISTICS

Mobile and intensive mental health services occurring in the community at locations convenient to the consumer	Included
Multidisciplinary, highly trained mental health teams	Included
Staff to client ratio of 1:10	Included
Assignment of a personal services coordinator to manage the consumer's care	Included
Client directed care utilizing recovery principles	Included
Outreach to consumers and their family (when permitted by privacy laws)	Included
Linkage, referral and coordination to psychiatry, psychology, housing, substance abuse, vocational and veterans services	Included
Forced or involuntary medication	NOT Included
Guaranteed or Forced housing placement	NOT included

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Guaranteed vocational placement or training	NOT included
Additional funding from Department of Health Care Services (DHCS) or other sources	NOT included

Eligibility criteria of Laura's Law requires that consumers be over the age of 18 with a diagnosed mental illness, exhibit deterioration of their condition, and be unlikely to survive in the community without supervision. Additionally, the consumer must have a history of treatment noncompliance, as evidenced by either two hospitalizations or incarcerations due to mental illness in the previous 3 years, or one or more acts of serious and violent behavior, threats, or attempts to harm themselves or others in the previous two years. The consumer must have been offered opportunities to participate in another high intensity treatment, such as Full Service Partnership (FSP) Assertive Community Treatment (ACT) services, but continue to refuse to engage in services. Finally, there must be confirmation that AOT would be the least restrictive treatment setting needed, that engagement in the services would prevent deterioration or relapse, and that the consumer would benefit from AOT.

Laura's Law authorizes county behavioral health departments to assess individuals referred to the program to determine the eligibility of each consumer, per the aforementioned criteria. Counties may then pursue a court order for involuntary treatment of consumers deemed eligible and unwilling to engage in voluntary services. The petition for a court order must be submitted by the county Behavioral Health Director or their designee. Consumers can engage in the court process, maintain their legal rights, and have access to legal counsel throughout the legal proceedings.

AB 1421 states that if a judge determines that it is appropriate, they can issue a court order for up to 6 months mandating AOT treatment. This initial order can be extended for an additional 6 months if the consumer still qualifies. The county Behavioral Health Department is required to provide an affidavit to the court every 60 days affirming that the consumer still qualifies for AOT and the consumer can petition the court to remove the order at any time.

Laura's Law specifically states that failure to comply with the court order alone is not grounds for conservatorship, a 5150 hold, hospitalization, incarceration, or a contempt of court citation. Additionally, consumers who refuse to comply with the court order cannot be mandated to receive other services, housing, or medication solely based on their lack of compliance.

Per AB 1421, Laura's Law can be implemented in any county where the Board of Supervisors votes to opt-in to the law. As part of the process, Laura's Law does not mandate that the county add mental health services; however, it does require that the county not eliminate services in order to fund AOT services. AB 1421 does not provide additional state or federal funding for implementation of AOT.

PROJECT OVERVIEW

BHRS engaged The Results Group to develop a set of recommendations for Stanislaus County focused on four goals:

1. Identification of the potential benefits and consequences of implementing Laura's Law.
2. Discussion of alternatives to implementation.
3. Identification of strengths within BHRS that can be built upon to enhance or replace implementation of Laura's Law.
4. Analysis of the current system of care available for consumers who could be impacted by Laura's Law.

METHODOLOGY

The Results Group employed a mixed-methods, evaluative approach to collecting information to help guide the analysis and make recommendations about implementation of Laura's Law. Specifically, these methods included:

Community Input

- Five facilitated community forums (3 in English for wide community; 1 in Spanish, and; 1 targeted to consumers) with local stakeholders to provide an overview of Laura's Law and solicit public comment.
- Pre- and post-test surveys administered prior to and directly following community forum events for the purpose of capturing knowledge gains about components of Laura's Law and attitudes toward its implementation.
- A web-based, online survey disseminated widely throughout the community for those individuals unable to attend a community forum in person. The survey included PowerPoint slides presented at the forums and captured knowledge gains and attitudes toward implementation.

Comparative Analysis of California counties.

- Key informant interviews and document review (e.g. reports to Boards of Supervisors) with counties, both those who chose to implement Laura's Law and those who chose not to implement, to gain perspective on both sides.
- Comparison of these counties with Stanislaus County.

System Evaluation

- Key informant interviews with county and community stakeholder leaders to provide an overview of Laura's Law and identify areas of interest and concern.
- Complete analysis of BHRS system of care capacity for the potential implementation of Laura's Law.

Data collection occurred over a period of 4 months from March-June, 2017.

RELEVANT EVIDENCE-BASED RESEARCH

Prior to engaging in the direct data collection activities, The Results Group scanned the relevant peer-reviewed research literature to determine the evidence base for AOT¹. In 2015, The Substance Abuse and Mental Health Services Administration (SAMHSA) added AOT to their National Registry of Evidence-based Programs and Practices (NREPP). However, the current evidence does not conclusively suggest that AOT is more effective than ACT or ICM. In their review of existing literature on AOT for a study on implementation of the practice, researchers noted that the existing literature suggests that participants of AOT have lower odds of arrest, reductions in hospitalizations and Emergency Department use, and improved engagement of services (Meldrum, et al., 2016). However, these studies have notable methodological flaws that limit their internal validity, such as absence of a control group, nonrandom assignment to AOT, and use of retrospective rather than prospective designs. When such methodological weaknesses exist, it is difficult to conclude that the results achieved were, in fact, due to the intervention itself. A Cochrane systematic review, which looks at the evidence across research articles, reviewed three trials with 749 individuals comparing “compulsory community treatment” with voluntary care and found that it was no more likely to result in better service use, social functioning, mental health functioning, or quality of life compared to voluntary care (Kisely, 2017).

Often times, the “black robe effect,” or the notion that a judge’s order is a powerful motivator, is cited as the mechanism by which individuals will comply with the court ordered treatment. This is not supported in the research literature—one recent qualitative study on AOT found that while three informants attributed the success of AOT to the “black robe effect,” four other informants did not find evidence that a judge’s involvement had any additional enforcement effect (Meldrum, et al, 2016). Finally, actual data provided by the probation department of Stanislaus County indicates that 60% of individuals who go through mental health court drop out, reinforcing the limitations of the black robe effect for compliance.

COMMUNITY INPUT

Approximately 200 unduplicated individuals, including family members, advocates, consumers, behavioral health providers, homeless service providers, police and probation department representatives, elected officials and a judge participated in five community forums facilitated to engage local stakeholders. Participants were provided with an informational presentation on the content of Laura’s Law and engaged in a question/answer session to provide additional information on the law. The structure and content of the presentation was explicitly designed to be neutral and focused on the factual aspects of the law. Participants were then broken into small groups for further discussion of Laura’s Law, including review of potential benefits of the law, concerns about the law, and gaps in the current system of care. Efforts were focused on identifying and receiving input from individuals local to the community and those that had not

¹ It was beyond the scope of work for this project to do a comprehensive, independent literature review, but we examined meta-analyses and reviewed secondary sources that summarize the state of the literature.

yet participated in the discussions. Facilitators worked to identify county residents and those who had not previously attended a Laura's Law forum to ensure that their voices were heard.

Additionally, a pre- and post-test survey was administered prior to and after community forum events for the purpose of capturing community attitudes related to Laura's Law and any shifts in knowledge that may have occurred following the informational presentation.

An online survey was also developed to allow for additional community input from residents who were unable to attend an in-person session. This survey included a link to the informational materials presented in the focus groups, and was designed as a post-test only instrument.

COMPARATIVE ANALYSIS – COUNTIES

Several counties have been engaged in the comparative analysis process by the consultants. County specific information has been obtained and/or telephone interviews have occurred to discuss the determination to implement or not implement Laura's Law and, when the county had implemented the law, the current program structure and outcomes. The following counties have engaged with The Results Group consultants:

- San Francisco –implemented 2015
- Marin – decided not to implement initially; new board members decided to implement in 2017
- Kern –implemented 2015

Additionally, one The Results Group consultant participated in a statewide Laura's Law conference call, where representatives from implementing counties presented information on their programs and engaged in discussion of challenges they are facing in their implementation. Counties that participated on the call included:

- Alameda
- Contra Costa
- Kern
- Los Angeles
- Orange
- Placer
- San Diego
- San Francisco
- San Luis Obispo
- Santa Barbara
- Ventura

Finally, at the request of BHRS, Yolo County and Nevada County implementations were reviewed based on written documentation available from the counties directly. Information about counties filtered through advocacy organizations was not included.

KEY INFORMANT INTERVIEWS

Consultants from The Results Group engaged BHRS staff and community stakeholders in key informant interviews to obtain information on the components of the system of care serving SPMI adults, the strengths of the system, and potential system gaps. Additionally, these interviews included discussion of the potential positive and negative impacts of Laura’s Law implementation on consumers and the system of care. Individuals were identified to participate by BHRS leadership and were engaged in phone interviews to discuss the above topics. Table 2 lists individuals who participated in key informant interviews.

TABLE 2 - KEY INFORMANTS

Name	Organization	Position
Debra Buckles	BHRS	Public Guardian and Chief of Forensics Services
Kevin Panyanouvong	BHRS	Chief of Adult System of Care
Pam Esparza	BHRS	Chief of Housing and Consumer Affairs, Supportive Employment
Shannyn McDonald	BHRS	Chief of Transition Age Youth System of Care
Mike Wilson	BHRS	Supervisor of Forensics Services
Dr. BJ Mora	BHRS	Psychiatrist
Dr. Phil Trompetter	BHRS	Community Psychologist, Forensic Assessor
Linda Mayo	National Alliance on Mental Illness, Stanislaus Chapter	Member
Rhonda Allen	National Alliance on Mental Illness, Stanislaus Chapter	Member
Mike Hamasaki	Stanislaus County Probation Department	Chief Probation Officer
Leticia Ruano	Stanislaus County Probation Department	Assistant Chief Probation Officer
John Bettencourt	Stanislaus County Probation Department	Deputy Probation Officer III
Lorena Palacio	Stanislaus County Probation Department	Deputy Probation Officer II

COMMUNITY INPUT

Five community forums were convened to maximize participation from Stanislaus County residents. Three of the focus groups had a broad target audience; one was conducted in Spanish to reach the bi-lingual or monolingual Latino population, and; one was targeted specifically for consumers. Data from the post-tests collected at the end of each session indicate the forums were successful in educating community members about Laura’s Law—87% of respondents agreed with the statement “Did your knowledge Laura’s Law increase as a result of our community forum?” A similar number (85%) stated they were satisfied with their overall experience at the community forum.

RESULTS FROM PRE- AND POST-TESTS

Knowledge about specific elements of Laura's Law also increased as a result of the community forums (Table 3).

TABLE 3 – KNOWLEDGE GAINS FROM COMMUNITY FORUMS

	I understand the eligibility criteria for individuals to receive services under Laura's Law. (Pre-test)	My understanding of the eligibility criteria for individuals to receive services under Laura's Law increased. (Post-test)
Strongly agree/agree	32%	85%
Neutral	17%	7%
Strongly disagree/disagree	17%	2%
Not sure	34%	6%
TOTAL	100%	100%
	I understand the referral process for getting an eligible individual into services via Laura's Law. (Pre-test)	My understanding of the referral process for getting an eligible individual into services via Laura's Law increased. (Post-test)
Strongly agree/agree	29%	82%
Neutral	16%	10%
Strongly disagree/disagree	27%	4%
Not sure	28%	4%
TOTAL	100%	100%
	I have an understanding of what services are available to eligible individuals under Laura's Law. (Pre-test)	My understanding of what services are available to eligible individuals under Laura's Law increased. (Post-test)
Strongly agree/agree	29%	76%
Neutral	15%	12%
Strongly disagree/disagree	23%	7%
Not sure	33%	5%
TOTAL	100%	100%

The percentage of respondents who responded in the pre-test that they agreed Stanislaus County should implement Laura's Law was 39%, with nearly half (49%) responding "Neutral" or "Not Sure." After the presentation, more respondents were in favor of implementation, with 67% responding that they agreed with the statement "I believe Stanislaus County should implement

Laura's Law." Only 15% remained neutral or not sure, and 10% disagreed with implementation. It is worth noting that the percentage of consumers in favor of implementation at post-test was lower than the pooled averages (53% compared to 67%). More consumers responded in the post-test that they remained "Neutral" or "Not Sure" of implementation (37%).

The qualitative comments related to Laura's Law primarily reflected concerns about implementation, including a desire to hear directly from counties who have implemented to learn from their experience. There were also several comments about the lack of available ancillary services (e.g. housing) to fully complement Laura's Law implementation.

RESULTS FROM ON-LINE SURVEY

The purpose of the on-line survey was to replicate the community forum experience for those community members who were unable to attend in person. There were 244 responses to the on-line survey and a review of IP addresses indicate that it is unlikely that there were many duplicate responses. 89% of respondents indicated that their knowledge of eligibility criteria increased as a result of reviewing the available PowerPoint slides; 87% stated that their knowledge of the referral process increased, and; 86% stated that their knowledge of the services available to eligible individuals increased. 87% of respondents agreed with the statement "I believe that Stanislaus County should implement Laura's Law." There was notable congruence between the pre- and post-test surveys from the community forums and the on-line survey, both in terms of knowledge gains, as well as majority support for the implementation of Laura's Law. The qualitative comments written in the on-line survey were also similar to those raised in the community forums. Respondents wrote about their concern for the number of individuals with mental illness who are also homeless. One respondent stated:

"As a former Stanislaus County librarian I can attest to the number of mentally ill homeless in Modesto. They have no or little access to meds that could help them and many are to the point that they don't recognize that they need help. They are ostracized when they could be helped if only by involuntary treatment accorded under Laura's Law."

In addition to comments about helping homeless individuals with severe mental illness, there were multiple comments in favor of implementation of the law in hopes of "making the streets and community safer" and "helping those who are most vulnerable in our community."

RESULTS FROM FORUM DISCUSSIONS

After presenting the PowerPoint during the community forums, breakout groups were formed to discuss the following questions:

- 1) What are the issues and concerns that brought you here today?
- 2) Was there anything presented today that you didn't already know?
- 3) What are your thoughts about how Laura's Law might benefit Stanislaus County?
- 4) What are your concerns about implementing Laura's Law?
- 5) What resources and/or services are necessary to address the concerns you have raised?

Participants who attended the community forums included: consumers of mental health services, family members of individuals with mental illness, advocates, City and County public employees, individuals expressing concern/frustration with the current system of care,

individuals concerned about the number of individuals who are homeless in the county, and other residents of Stanislaus County who wanted more information.

Some of the most common responses to the second prompt, “Was there anything presented today that you didn’t already know?” included:

- The lack of legal consequences to the law “lack of teeth”
- No additional funding for the program, if implemented
- The strict eligibility criteria
- The 10:1 client to clinician ratio
- Confidentiality laws would not change in terms of family members being able to get information on their loved ones

Respondents had a great deal to say about how they thought Laura’s Law might benefit Stanislaus County. For many participants, there was a strong sense that the law might benefit their family members and loved ones with mental illness, with several participants expressing the belief that loved ones who succumbed to their mental illness might still be alive today if they had had Laura’s Law. There were many voices of parents, particularly, with adult children with mental health issues who expressed a hope that this law would help support their efforts to get them the critical help and services they need.

Other benefits identified included:

- Potential cost savings to the County due to reduced hospitalizations and incarcerations
- Increased housing stability for those at risk of or experiencing homelessness
- More coordination of services by the system of care
- A sense that Laura’s Law could help catch individuals from “falling through the cracks”

As far as concerns voiced by participants, the lack of consequences recurred as a theme. There were concerns that voluntary treatment may ultimately be more effective than court-ordered treatment, and related to this issue, making sure that the rights of individuals with mental illness are protected. Many expressed concern that implementing Laura’s Law without additional funds might take services away from other programs within the system of care, or that referrals to support services, such as housing and vocational training, would be impacted. Other concerns included whether undocumented residents would have access to services and how to address the language barriers for monolingual residents. Finally, there were many questions around what other counties were doing, how it was working, and whether there were specific lessons learned from them that could be applied to Stanislaus.

Lastly, when asked to identify additional resources or services, many suggestions for improving the current system of care were made. There was strong support of increasing housing availability, transportation services, preventative services, vocational training, and increased coordination of services within the County. Many respondents expressed a desire to have more peer support available and ensure that the consumer voice was heard. Other themes included: more available resource education to consumers and their families; adopting a “no wrong door” policy at the County so that consumers and family members can get the information and services they need; more outreach to encourage voluntary participation.

The community forums provided an important avenue for residents, including consumers and family members, to share their opinions, stories, ideas, and strategies and their input was invaluable to the process.

COMPARATIVE ANALYSIS

As described in the above methodology section, this project included a review of AOT implementation in other counties. Due to resource constraints, not every county that implemented could be included individually in the analysis, however information from a wide cross-section of implementing counties was obtained and integrated as available.

MARIN COUNTY

In January 2016, the Marin County Board of Supervisors declined to implement Laura's Law on the advice of the Marin Health and Human Services (HHS) Department. Information regarding this decision, including the Marin AB 1421 Workgroup Findings Report and presentation materials from HHS were reviewed in order to shed light on how and why a county might determine not to implement Laura's Law.

Marin County's workgroup expressed several concerns that led them to the recommendation that Marin not implement AOT. First, members felt that AOT services would be largely duplicative of Marin's robust engagement efforts, including their forensic, FSP and conservatorship programs. Though the workgroup felt that AOT might help the target population, they noted no conclusive evidence that it was more effective than their current interventions in reducing mental health symptoms or homelessness. The workgroup was concerned about the small number of potentially eligible individuals given the investment and intensity of services required to implement AOT.

The workgroup spent significant time reviewing the research base for AOT and felt that there was a lack of sufficient evidence showing that AOT was more effective than baseline interventions, including ACT. They reviewed the evidence that ACT FSP programs improve outcomes for consumers and the lack of evidence that adding a court order process to the ACT FSP programs would substantially improve outcomes for consumers. They also cite a lack of research into the cost savings, cost avoidance and cost increases of implementation of AOT. The workgroup expressed a desire to expand system capacity and implement evidence-based programs with fidelity to improve the system of care available to assist SPMI consumers. In March of 2017, Marin County HHS changed course and requested board approval on a list of health-care system expansion priorities, which included funding for a two-year Laura's Law pilot program. According to news reports, family advocates in Marin were hopeful that the pilot would result in care for those previously not engaged in treatment, while consumer advocates were concerned about a diversion of limited resources from current voluntary services and that the AOT process might inadvertently target communities of color. HHS Director Grant Colfax estimated that 7-12 people in Marin might be eligible and that approximately 5 AOT court orders might be necessary. Suzanne Tavano, Marin's director of Mental Health and Substance Use Services expressed concern that the care might be unfunded, if the consumer is not enrolled in Medi-Cal or other health coverage that includes mental health care.

SAN FRANCISCO

San Francisco's Department of Public Health (DPH) implemented AOT services in November of 2015, following review by a mayoral task force and approval by the Board of Supervisors. The DPH AOT program is structured as a partnership between a 3-person county AOT engagement and investigation team, led by a forensic psychologist, and the Citywide FSP team. The program director of San Francisco's AOT team graciously agreed to be interviewed by The Results Group and provided us with her 2017 AOT annual report. Additionally, she facilitated our involvement with the Statewide AOT conference call described in a later section.

The AOT team, funded by MHSA dollars, holds responsibility for receiving referrals, investigating eligibility, completing an initial assessment, attempting to engage consumers in voluntary services and the court petition, order and reporting processes. The Citywide team provides the direct intensive case management and medication support services, and links consumers to employment, housing and other services available from other DPH providers. Citywide, funded by Medi-Cal and MHSA, is not a formal ACT program, but utilizes ACT principles.

DPH AOT strives to engage consumers in voluntary services and includes a 60-day voluntary outreach period, which has assisted approximately 60% of eligible consumers to engage in FSP services on a voluntary basis. This focus on voluntary engagement has resulted in only 6 court orders and has ensured that the majority of consumers contacted are routed to the correct level of care.

Compliance with the court order was reportedly mixed for the DPH program. Per San Francisco's 2017 AOT Annual Report, one court ordered consumer was 100% compliant with court ordered treatment, where compliance is measured by at least one contact with a mental health provider each week during the court order period. The other five court ordered consumers were between 36% and 62% compliant with the court order, with four of these below 45% compliant. Table 4 below details the compliance rates for each San Francisco consumer court ordered to receive AOT.

TABLE 4- AOT CONSUMER COMPLIANCE WITH COURT ORDER (DPH ANNUAL REPORT)

	Court Order Length (Days)	Citywide Contacts	% of Weeks Compliant w/ Treatment
Participant 1	287	115	100%
Participant 2	301	66	36%
Participant 3	197	81	62%
Participant 4	196	38	40%
Participant 5	63	16	40%
Participant 6	42	10	43%

The DPH AOT Program Director noted that, while there are no direct consequences for lack of compliance with a court order, consumers are “likely to not need much more deterioration to qualify for a 5150 hold.”

Per San Francisco’s 2017 AOT Annual Report, outcomes of AOT engagement blended the results for court ordered and non-court ordered participants. Given that the court order is the unique aspect of AOT, as compared to ACT provided in the context of an FSP program, the report also distinctly reports the outcomes unique to the 6 court ordered individuals. For these individuals, visits to psychiatric emergency services (PES), hospitalization days and incarceration days per month were identified as outcome metrics for review. Table 5 provides details of the progress for each court ordered individual on these metrics.

TABLE 5 - OUTCOMES FOR COURT ORDERED PARTICIPANTS (DPH ANNUAL REPORT)

	PES Visits per Month		Days Hospitalized per Month		Days Incarcerated per Month	
	Pre	Post	Pre	Post	Pre	Post
Participant 1	0.33	0.00	1.5	0.0	0.0	0.0
Participant 2	0.24	0.00	6.9	2.4	0.9	0.0
Participant 3	0.25	0.00	1.8	6.7	0.0	2.5
Participant 4	0.00	0.00	0.00	2.5	0.0	0.0
Participant 5	0.39	1.00	1.2	2.0	9.4	3.5
Participant 6	0.18	0.00	1.5	0.0	0.0	0.0

This analysis, completed for the San Francisco AOT Annual Report, indicates that all but one participant reduced or maintained prior usage levels of PES, three participants reduced hospitalization days and two consumers reduced incarceration days, while one participant who had previously not been incarcerated showed an increase in incarceration days. However, the small sample size meant that aggregate information was not particularly meaningful.

KERN

Kern County Behavioral Health and Recovery Services graciously agreed to participate in an interview with The Results Group, where three members of their AOT Behavioral Health leadership provided information to us about Kern County’s AOT implementation. They described a two-stage process for AOT implementation, beginning in 2011. At that time, Kern County decided not to implement AOT, as they felt that the efficacy data for AOT was not strong and that their own ACT programs were not yet at high fidelity. The county instead focused on improving the quality of their ACT programs through robust fidelity monitoring. They also added a family advocate position and developed a strong team of outreach staff to provide “pre-AOT style engagement services.”

In 2014, Kern County revisited their AOT determination and identified that, although engagement was strong given their newly added services, there was still a small segment of the

SPMI population that they were not able to engage. Kern County brought together a community stakeholder group and worked with the Board of Supervisors to approve AOT implementation. Kern County's AOT team is embedded within their county based ACT teams. Kern AOT provides 30-day engagement period, which is extended if there is hope that the consumer will engage voluntarily. They noted that this engagement period helped to get consumer groups to agree with implementation of AOT, due to concerns about violating consumer rights if the county moved too quickly to a court order. These engagement efforts are largely successful, as Kern County reports having a high level of voluntary agreement and has not needed court orders mandating treatment.

Kern County staff identified several challenges in their AOT implementation to date, including confidentiality barriers, engaging and educating the community about AOT and having enough qualified staff to provide AOT and ACT services. Additionally, they noted that, though they work diligently to coach clients on accepting medication, these efforts are not typically successful. Given the lack of forced medication within AOT, this means that many of the consumers do not engage with medication management services.

A written copy of the Kern County AOT annual report was not available from Kern County at the time of this report's completion.

NEVADA

Nevada County was the first county in California to implement AOT in 2008 and has provided AOT services continuously since that time. The Nevada AOT program is a collaboration between Nevada County's Behavioral Health Department and Turning Point, a community-based organization. Between 2008 and 2015, Nevada County has received 67 unduplicated referrals for AOT and obtained court orders for 30 unduplicated consumers, or approximately 6 per year of implementation.

Given the length of Nevada County's implementation, they may serve as the best predictor of cost savings. Per the 2012 Grand Jury Report on Nevada County's implementation, they note an analysis indicating "that for each dollar Nevada County invested in providing services under Laura's Law, it saved \$1.81." This calculation seems to rely on calculations of hospital and incarceration days for 17 individuals during the year prior to AOT implementation and extrapolation of what their hospitalization and incarcerations days would have been without treatment over 2 .64 years. By 2015, Nevada County noted that the AOT costs were similar to the cost of providing ACT services for SPMI individuals.

Nevada County has a different approach to medication within the AOT context as compared to other county implementations. It seems, from materials available on the Nevada County AOT website, that the judges providing AOT court orders in this jurisdiction include medication on the court ordered individual service plan. Nevada County affirms that these medications are not forced, but are rather court ordered. However, the distinction between the definitions of court ordered and forced medications in this context is unclear.

In 2015, Turning Point provided data comparing 12 months pre-treatment and 12 months post-treatment based on unduplicated court ordered individuals served in fiscal year 2014-2015. Per this report, Nevada County AOT participants saw a reduction of hospital days by 68%, incarceration days by 100% and homeless days by 100%. It should be noted that the methodology for calculating these percentages is not well-articulated in the report. Additionally, the sample size is small (6 clients), therefore extrapolation based on this data should be limited. Finally, additional information about the exact structure, funding and nature of Nevada County's AOT implementation would be necessary in order to draw any conclusions from this data.

YOLO

Yolo County fully implemented Laura's Law in 2014, following a year-long pilot, becoming the second county to implement AOT in California. Turning Point Community Programs has been contracted as the Yolo County AOT provider since 2013. Turning Point completes the DHCS mandated annual report on behalf of Yolo County each year and provided The Results Group with a copy of their most recent annual report, covering fiscal year 2015-2016.

Turning Point provides AOT services utilizing several evidence-based practices, including ACT, Moral Reconnection Therapy (MRT) and Cognitive Behavioral Therapy (CBT). Additionally, Turning Point provides AOT consumers with a dual diagnosis group to integrate treatment for psychiatric and substance abuse disorders and a "Building Bridges Group" that develops consumer skills and disseminates resources in a supportive environment. Turning Point also offers a Transitional Age Youth group and an art therapy group to address consumer needs. In the fiscal year covered by the provided report, eight consumers were served by AOT in Yolo County, with only one of the consumers representing a new enrollment. The other seven consumers had been enrolled during the previous fiscal year. Five of the eight consumers were discharged during the 15-16 fiscal year, with four discharging to ongoing mental health services and one consumer discharging due to incarceration.

The AOT program in Yolo County aims to achieve several goals, including decreasing hospitalization usage, jail days and days of homelessness. Turning Point reports that three individuals experienced an increase in psychiatric hospitalization days during fiscal year 15-16, while five individuals were not hospitalized. Three consumers experienced a significant increase in days incarcerated, with two of these consumers spending a total of 160 days in jail. In contrast to these mixed results, the program did see a dramatic decrease for the one consumer who had experienced homelessness in the previous fiscal year, with the days spent homeless decreasing from 90 in fiscal year 14-15 to 4 in fiscal year 15-16. It should be noted that the Turning Point program is listed as providing stable housing assistance and support, which appears to describe housing services above and beyond those required by AB 1421. Given the small sample size, it is challenging to interpret aggregate information regarding consumer outcomes. Additional information about the exact structure, funding and nature of Yolo County's AOT implementation would be necessary in order to draw any conclusions from this data.

STATEWIDE AOT CONFERENCE CALL

The Results Group was honored to be invited to participate in a conference call hosted quarterly for counties engaged in AOT service provision across the state in April. Nearly all counties that have implemented or are in the process of implementing AOT participated in the call. During the call, each county reviewed referral, voluntary engagement, petition and court order information and utilized the forum to ask and answer AOT implementation questions.

A prominent topic of conversation was managing the referral process. Most participating counties noted that they receive many referrals that are not eligible for AOT, typically due to a lack of severity of symptoms and/or infrequent hospitalizations. Referrals seem to be coming from treatment providers and family advocacy entities in many counties and those on the call identified that some of these groups were not clear on the stringent eligibility criteria for AOT. Counties with strong engagement with their law enforcement partners noted that referrals from these partners were more likely to be eligible, but other counties noted a struggle to inform and engage law enforcement in the referral process. For both of these issues, counties identified educational presentations as helpful in changing the nature of the AOT referrals received. They also noted universally that ineligible individuals are referred to other programs for which they may be eligible, including FSP and homelessness prevention programs.

The clear majority of referrals in most counties engage voluntarily in FSP services after vigorous outreach by the county's behavioral health department staff. Many counties use a "voluntary engagement period" lasting from 30-90 days following establishment of eligibility for AOT, though several counties stated that they frequently extend the engagement period. Counties report that this is a useful period, as they prefer to engage consumers voluntarily in FSP services in lieu of filing for a court order. During this period, AOT staff engage in robust engagement activities, visiting consumers where they are located and attempting to identify an area, such as housing or vocational services, where the consumer will actively engage.

"We'll extend the engagement period as long as it takes to engage a person, if they're at least talking to our investigation staff."

County AOT provider

Confidentiality was a significant issue for AOT providers on the call, who discussed struggles with sharing information with law enforcement and crisis care entities due to the frequent refusal of consumers to sign a release of information. This lack of coordination limits the ability of counties to locate consumers and, in some counties, restricts the ability of AOT providers to identify if consumers have been incarcerated or hospitalized. At least two counties stated that they are not permitted by their county counsel to use Electronic Health Record information in their investigation of a consumer's eligibility and therefore must rely on the consumer's admission of hospitalization or incarceration to establish eligibility.

Counties generally reported a low number of court orders with half of the counties who presented data reporting no court orders. Some counties stated that their implementation was too recent to have completed any court orders and more experienced counties counseled that the first court order typically takes place between month 6 and month 12 of a county's AOT

implementation. For those who discussed compliance with the court orders, consumer compliance with the AOT court order was mixed.

Counties also reported many consumers designated as “unable to locate”, meaning that the consumer was not able to be evaluated for AOT eligibility. County staff report struggles to locate referred consumers in order to complete assessment and investigate as necessary to determine eligibility for AOT. At times, they can locate a consumer and establish eligibility, but struggle to locate the consumer for engagement, outreach and/or in order to serve court petition or court order. Some counties engage crisis staff in the search, while others do “ride alongs” with neighborhood patrol officers in attempts to find consumers. Most counties note that they close an AOT referral that they are unable to locate after 30 days of searching.

The specific data from each county shown in Table 6 below was provided during this call by participating counties. It is worth noting that the data provided in Table 6 has some significant limitations. First, each county uses slightly different language for various client statuses, which creates a lack of data consistency when reviewing information from across counties. Counties also provided information across different time periods, with some using year to date data while others used data from their entire implementation. During the call, some counties noted that they move more quickly towards a court order, while others implemented multi-month voluntary engagement periods prior to filing an AOT petition. Finally, cross-county comparison is challenging due to the wide variety of implementation strategies between counties. For example, Los Angeles County established a committee that reviews all referrals, while San Francisco referrals are reviewed by the AOT program director.

Ventura County has a unique AOT perspective, as their implementation is partially funded by a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). This has provided Ventura with a federal perspective and they discussed that SAMHSA is highly critical of the California data because counties are clouding the AOT data by including individuals who are not court ordered. SAMHSA, per Ventura County, would not consider such individuals as being enrolled in or part of an AOT program and believes that AOT enrollment should begin at the point of an approved court order mandating outpatient treatment.

TABLE 6 – COUNTY AOT CONFERENCE CALL DATA

County	Referrals	Consumer referred to/engaged in voluntary services	Court Orders
Contra Costa	Not reported	Not reported	21
Kern	86	34	0
Los Angeles	534	Not reported	27
Orange	518	90	27
Placer	18	8	2
San Diego	119	82	0
San Francisco	135	23	6
San Luis Obispo	44	22	0
Santa Barbara	17	Not reported	0
Ventura	49	12	0

AOT COST INCREASES AND REDUCTIONS

Based on the above information, counties experience both cost savings and cost increases when AOT is implemented. In addition to reducing hospitalization rates, counties can experience a reduction in psychiatric emergency services, emergency room utilization, incarcerations and use of law enforcement to provide mental health intervention. However, counties also experience increases in the costs of implementing the AOT program itself, additional FSP services, housing programs and legal services, including county counsel, public defender and court costs. Access to specific information on the fiscal impact of AOT provided directly from California counties is limited, though advocacy organizations often tout unverified data from online sources.

As noted in the key informant interviews section, funding for AOT services is a significant concern for all involved. Counties have taken a variety of approaches to funding AOT, with some focused on grants, others using general fund and many using Mental Health Services Act (MHSA) funds. Limited resources are available to cover the increases in legal costs, particularly for contested AOT petitions. Annual reports reviewed for the comparative analysis section of this report did not include specific information on cost savings or increases.

STANISLAUS RESIDENTS POTENTIALLY ELIGIBLE FOR LAURA'S LAW

One of the most frequently asked questions for stakeholders in the community input process was “How many individuals might be eligible for services under Laura’s Law in Stanislaus County?” While it is not possible to know the exact number, two methods were used to generate an estimate. First, we borrowed an epidemiological, population-based methodology that has been used by other counties and jurisdictions to estimate the number of potentially eligible.² This approach assumes that 1 in 25,000 may be AOT eligible, based on distribution of severe mental illness in a given population and the experience of states such as New York and North Carolina. US Census Population 2016 estimates indicate there are 541,560 residents in Stanislaus County, which would mean 21 individuals are estimated to be eligible for AOT. The second methodology used is to use actual data from Stanislaus County’s Data Management Services, a division of Behavioral Health. In looking at the number of individuals hospitalized/incarcerated 6 or more times for the six-month period between 10/31/16 and 4/30/17, there were 18 unduplicated individuals. It is reasonable to estimate that over a 12-month period, approximately 36 individuals would fall into this category. However, not all of these individuals would meet the strict criteria outlined in Laura’s Law and some of them may already be engaged in services voluntarily. Based on our conversations with other counties, their experience suggests that the eligible number would be on the lower end of these estimates (21 rather than 36).

² This methodology was described in Marin Health & Human Services: Report on the AB 1421 Workgroup Findings, a report by Resource Development Associates in their report to Marin Health and Human Services regarding Laura’s Law adoption. The report can be found on-line [here](#).

KEY INFORMANT INTERVIEWS

BHRS provides a robust continuum of care for residents of Stanislaus County, including mental health and substance abuse services. BHRS, under the leadership of Behavioral Health Director Richard DeGette, has a stated commitment to continuous quality improvement of services available to all consumers, including increased use of and fidelity to evidence-based practices, expanding the continuum of care and improving access to services. For the purpose of this evaluation, specific attention was paid to the services available to consumers with SPMI within the Adult System of Care. Appendix D shows the programs within the Adult System of Care, designated by level of care provided to consumers.

BHRS Mission Statement

“In partnership with our community, our mission is to provide and manage effective prevention and behavioral health services that promote the community’s capacity to achieve wellness, resilience, and recovery outcomes.”

FULL SERVICE PARTNERSHIPS – ASSERTIVE COMMUNITY TREATMENT

The highest intensity programs in the Stanislaus System of Care are Full Service Partnership (FSP) programs, which utilize an Assertive Community Treatment (ACT) model. The ACT model is a treatment that provides intensive, multi-disciplinary and “wraparound-like” services to adults with SPMI and includes linkage and coordination with psychiatry, housing, vocational, and other necessary services. ACT, when done with high fidelity, very closely resembles the description of AOT services found in AB 1421. These FSP programs are jointly funded by Medi-Cal and Mental Health Services Act (MHSA) dollars and are intended to provide consumers with services several times per week, as determined by each individual’s need. BHRS provides several FSP programs and collaborates with community based organizations to provide additional FSP services. The current array of FSP services includes those tailored to Transition Age Youth, Older Adults, Forensic consumers and Dual

What is ACT?

Assertive Community Treatment (ACT) is an evidence-based practice for consumers with severe and persistent mental illness that provides comprehensive, intensive, multi-disciplinary services.

Diagnosis Medical/Mental Health consumers.

To become eligible for an FSP program, consumers must have serious and persistent behavioral health/psychotic symptoms and acute and major impairments in ability to function. Consumers eligible for FSP services typically exhibit high utilization of hospitalizations or forensic mental health services due to their diagnosis. These consumers also often have behaviors that put themselves or others at risk of harm, have poor connections to natural supports, have a lack of engagement in mental health services, and/or are homeless or at risk of homelessness. Some FSP programs have additional eligibility criteria, such as Josie’s Place, which specifically aims to serve adults between the ages of 18 and 25, or HRSHA, which targets individuals over the age of 55 or adults of any age with significant co-occurring physical health concerns.

For every individual hospitalized in Stanislaus County, the BHRS staff begin a period of intensive engagement activities to begin the enrollment process into behavioral health services. This engagement begins by starting “where the consumer is”, meaning that the BHRS staff focus on the areas of life where the consumer wants assistance even if that assistance is not directly related to mental health treatment or medication. Per BHRS staff, consumers often engage when

“Every individual who is hospitalized in Stanislaus County is met by a BHRS staff member who works to connect them to behavioral health care services.”

BHRS Staff Member

first assisted with housing or employment services rather than mental health services. When new consumers enter the Adult System of Care, they begin with FSP services to improve the likelihood that they engage in services and stabilize their symptoms.

Engagement efforts are particularly robust for the forensic teams, which targets individuals who are deemed incompetent to stand trial or those scheduled for post-release community supervision. Forensic FSP staff work to connect

with consumers while they are incarcerated and continue services upon release. Incarcerated individuals with high levels of mental health needs are picked up at the jail or prison when released to begin coordination for housing placement and mental health services immediately. BHRS staff coordinate closely with judiciary and probation staff to increase the leverage for consumers to engage in mental health treatment. Stanislaus County has a robust mental health court, staffed with Forensic FSP staff and Probation Department staff, which allows individuals to receive mental health treatment in lieu of criminal court proceedings. If the consumer graduates from mental health court services, they suffer no conviction and charges are dropped related to the criminal activity. Additionally, probation officers work with embedded BHRS FSP mental health teams to apply pressure to consumers to comply with treatment. In both situations, legal consequences can be applied to individuals who do not comply with the court or probation orders for mental health treatment.

The best current proxy for the potential impact of Laura’s Law on consumer compliance with mental health treatment is found in the experience of the Forensic FSP treatment providers. The intensive ACT services provided by the FSP program are combined with court orders for mental health treatment in a way that is quite similar to what is outlined in AB 1421. Therefore, compliance with treatment in these programs was of particular interest during key informant interviews.

When asked about the compliance with treatment in these situations, both BHRS FSP and Probation department staff noted that compliance with court orders is inconsistent. According to probation department data, approximately 60% of individuals enrolled in mental health court drop out of treatment prior to graduating the program. Individuals familiar with this program noted that most of the SPMI consumers they have encountered act with great impulsivity and that this leads to impulsively leaving mental health treatment and/or housing placements despite the potentially

“The threat of going to court even with possibility of jail time isn’t effective in getting individuals to comply with mental health treatment.”

Probation Department Official

negative legal consequences. It is not the reported experience of those working in the Stanislaus forensic system that the “black robe effect” is real in the lives of the consumers they serve.

LPS CONSERVATORSHIP

LPS Conservatorship presents another current avenue for mandated intervention with some of the most acutely mentally ill individuals in Stanislaus County. When a consumer is consistently unable to provide for their own food, clothing, and shelter and refuses support in these areas, they are considered gravely disabled and may be eligible for LPS Conservatorship. Eligibility criteria for conservatorship are quite narrowly constructed, as individuals who are conserved lose their legal right to make decisions for themselves.

On the path to conservatorship, individuals must go through several stages of involuntary legal holds to ensure that conservatorship is necessary. Appendix D shows a flow chart of the holds leading to conservatorship. Once conserved, most individuals are placed in locked facilities and are court ordered to take medication. Conservatorship can be temporary or permanent and BHRS staff report that the ability to mandate a consumer to take medication is a primary driver of success for individuals who are able to exit temporary conservatorship before it becomes permanent. BHRS staff note, however, that even though medication can be mandated, they “can’t force someone to swallow.” Therefore, not all individuals mandated to take medication comply with the order.

PROGRAM COMPARISON

In order to provide clarity about the similarities and differences between AOT, FSP programs and LPS Conservatorship, Table 7 outlines eligibility criteria for all three services while Table 8 compares characteristics of these services.

TABLE 7- ELIGIBILITY CRITERIA FOR AOT, FSP AND CONSERVATORSHIP

Eligibility Criteria	Assisted Outpatient Treatment	Full Service Partnership (ACT)	LPS Conservatorship
18 years or older with severe and persistent mental illness	✓	✓	✓
Under 18 years old with severe and persistent mental illness	✗	✗	✓
Unlikely to survive in community without supervision	✓	✓	✓
Frequent hospitalizations	✓	✓	✓
Significant difficulty maintaining stable residence	✗	✓	✓
Significant inability to engage in productive activities and daily responsibilities	✗	✓	✓

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Significant inability to manage physical health problems	✗	✓	✓
Multiple needs and little/no community support	✗	✓	✓
Frequent incarcerations or use of forensic mental health services	✓	✓	✓
Requires close medication management follow-up and/or requires multiple medications	✗	✓	✓
History of being offered mental health treatment but refuses to engage in voluntary services	✓	✗	✓
Refuses to accept assistance with food, clothing or shelter	✗	✗	✓
Condition deteriorating	✓	✓	✓
Evidence of grave disability	✗	✓	✓
At risk of being conserved or history of conservatorship	✗	✓	✗
Service would be least restrictive treatment/service appropriate	✓	✓	✓
Services believed to be beneficial and prevent deterioration/relapse	✓	✓	✓

TABLE 8 - CHARACTERISTICS OF AOT, FSP AND CONSERVATORSHIP

Treatment Characteristics	Assisted Outpatient Treatment	Full Service Partnership (ACT)	Conservatorship
Mobile and intensive mental health services occurring in the community at locations convenient to the consumer	✓	✓	✓
Multidisciplinary, highly trained mental health teams including clinicians, case managers, nurses and psychiatric providers.	✓	✓	✓
Staff to client ratio of 1:10	✓	✓	✗
Assignment of a personal services coordinator to manage the consumer's care	✓	✓	✓
Client directed care utilizing recovery principles	✓	✓	✓

Outreach to consumers and their family (when permitted by privacy laws)	✓	✓	✓
Linkage, referral and coordination to psychiatry, psychology, housing, substance abuse, vocational and veterans' services	✓	✓	✓
Court intervention mandating treatment	✓	✗	✓
Forced or involuntary medication	✗	✗	✓
Guaranteed/Forced housing placement	✗	✗	✓
Guaranteed vocational placement or training	✗	✗	✗

SYSTEM OF CARE ANALYSIS AND FIT FOR LAURA'S LAW IMPLEMENTATION

Nearly every individual who engaged in key informant interviews identified aspects of the BHRS System of Care that could be strengthened and expressed concern about the impact of Laura's Law implementation. The primary areas of focus for improvement were adding new services, increasing capacity for existing services, and improving fidelity for current evidence-based practices. The most frequently cited concerns were related to draining BHRS resources and a "lack of teeth" in the law to compel compliance.

Many of the individuals interviewed stated a belief that Laura's Law would give the appearance of providing a new intervention (e.g. the court order for outpatient treatment); however, in fact, it would not change the engagement of the targeted individuals in the mental health system. The lack of consequences for not complying with the court order was cited again and again by interviewees as a significant concern about implementation of Laura's Law. While some individuals spoke with hope about the impact of the "black robe effect," those working directly in the forensic system noted that their anecdotal experience is that this effect is not present in the majority of cases. One staff member noted that there is "long-term harm" to attempting to apply a mandate with no consequences, as it makes the consumer less likely to comply with treatment over time, in their experience.

Another common concern was the lack of involuntary medication in Laura's Law. Individuals who work closely with the SPMI population universally noted that compliance with a medication regimen, whether voluntary or involuntary, increased insight and treatment compliance. The consumers who would be eligible for Laura's Law are among the least likely to agree to medication in the experience of BHRS staff. The experience of BHRS staff working with individuals under court order to take medication, be it through conservatorship or forensic mental health services, is that not all individuals comply with the order and do not take their medications consistently.

The impact of Laura's Law implementation on the conservatorship process felt unclear to many individuals interviewed. In order to be conserved, individuals must have exhausted all other intervention options. Therefore, the possibility exists that judges in Stanislaus County would require that individuals be enrolled in Laura's Law prior to engaging in the conservatorship process, which could potentially delay conservatorship for individuals who are in need of that highest level of care.

The Focus on Prevention initiative currently underway in Stanislaus county was discussed by several interviewees as critical to address the current needs of SPMI consumers. This ten-year initiative is intended to improve access to intensive mental health services, reduce homelessness, strengthen families and reduce incarceration. A vision of a Services Hub that brings together medical, homeless and mental health providers together to serve high need consumers was described as of high value to the citizens of Stanislaus. Individuals expressed concern that implementation of Laura's Law would distract attention and funds from this initiative.

While the clear majority of people interviewed expressed concerns about implementation, there were a few individuals who were strongly supportive of implementation. In these conversations,

"A lack of willingness to engage in services means that people don't receive services. How does that seem right?"
NAMI Member

the "black robe effect" was discussed as a strong source of hope for families and others who feel that high need consumers have not been sufficiently motivated to engage in care. Reliance on the court order to compel compliance was a paramount theme in discussions with supporters of implementation. Some individuals expressed hope that consumers could be forced to take medications and were disappointed that this was not included in Laura's Law because of a belief that consumers would be more

likely to engage in FSP services if they were medicated.

Several increases in services were identified by interviewees as necessary within Stanislaus County. Adding capacity to serve more consumers with FSP programs were frequently noted as necessary, regardless of the decision about Laura's Law implementation. Individuals stated that substance abuse services were in short supply, particularly for individuals diagnosed with both a substance abuse and mental health disorder.

Several individuals noted that Stanislaus' FSP programs are quite strong, but noted that an increase in fidelity to the ACT model, ongoing fidelity monitoring, and adding staff to create capacity to serve more consumers would be improvements that would create higher quality of care in these programs. Staff in these programs expressed concern that implementation of AOT, given its high duplication of existing FSP/ACT services, would in fact drain resources away from the FSP programs and increase workload without creating an increase in capacity. Some expressed concern that AOT eligible clients would take existing FSP slots, having a negative impact on current FSP clients who would need to be referred to lower levels of care due to a lack of capacity in the FSP

"Without additional funding, I'm worried that AOT eligible clients would push non AOT eligible FSP clients into lower levels of care that aren't appropriate for them."
BHRS Staff Member

programs. One staff even noted that he was concerned that hospitalization rates might increase in Stanislaus County for consumers “squeezed out” of FSP programs. Other interviewees noted concern about the overlap between existing services provided by BHRS and those outlined in Laura’s Law and feared that implementation would create a duplication of services that would ultimately be more challenging for individuals trying to navigate the mental health system.

Supported employment services that could be utilized by consumers at various levels of impairment were identified as critical to consumer success and as an area where BHRS is investing to improve access. However, supported employment caseloads are currently at approximately 1 staff to 50 consumers, making it difficult for the staff to provide an intensive level of employment support that would be needed by the highest need consumers. A forthcoming pilot project of Individual Placement and Support (IPS) services is anticipated to provide FSP level support using an employment first model and was noted as critical in improving access to appropriate employment services for individuals currently receiving ACT mental health services. However, a concern that Laura’s Law implementation would drain resources from this pilot was identified by some respondents.

The largest gap identified by nearly all interviewees was a lack of supported housing options. Waiting lists are reportedly long for all types of housing services due to many factors outside of the control of BHRS. BHRS staff report a near 80% reduction in licensed Board and Care facilities within Stanislaus County in the last 10 years due to increased housing costs and stagnant rate structures from the state. These same factors have limited BHRS’ ability to purchase more permanent supported housing units or lease transitional housing units as well. However, consumers in the highest need of housing support and embedded treatment services may not qualify for permanent or transitional housing, as consumers must be able to independently manage their medication because BHRS staff are not present on-site 24 hours a day.

DISCUSSION

Throughout all phases of this project, opinions for and against implementation of Laura’s Law were identified and explored. A summary of the most frequently identified reasons to implement or not to implement are listed in Table 9 below.

TABLE 9 - REASONS TO/REASONS NOT TO IMPLEMENT LAURA’S LAW

Reasons to Implement Laura’s Law	Reasons Not to Implement Laura’s Law
<ul style="list-style-type: none"> • Could help eligible consumers who are not engaged in treatment • Adds a layer of mandated treatment not currently available • A sense that there are gaps in the system of care resulting in the most in need falling through the cracks • May help avoid use of conservatorship 	<ul style="list-style-type: none"> • Number of eligible consumers likely to be small • Lack of ability to enforce court order or apply consequences for non-compliance • Does not include mandated medication in the court order • Cannot mandate housing/may not reduce homelessness

<ul style="list-style-type: none"> • Reduce costs for incarceration and hospitalization • Strong support from family advocacy groups • May reduce number of individuals experiencing homelessness • May help improve the safety of the community 	<ul style="list-style-type: none"> • Outside of court order, largely duplicates current services and engagement efforts • May delay conservatorship for those who need it • Increase in costs for court efforts and increased services • May divert fiscal and human resources better spent improving current services with more evidence-based support of effectiveness • Limited availability of housing resources limits ability to achieve community expectations
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Community input: There was majority support for implementation of Laura’s Law in Stanislaus County by participating community members. However, many community members who responded in the pre-test that they did not know the details of Laura’s Law (e.g. eligibility criteria) nonetheless stated that they were in support of implementation of the law. It seems that many may have made up their mind about the law before fully understanding the details and limitations. Many of the qualitative comments in the on-line survey expressed concern for the number of individuals who are homeless, living on the streets, and thought that Laura’s Law might be a tool to reduce those numbers. While Laura’s Law may impact the homelessness issue, currently, the lack of supported housing in Stanislaus would create significant barriers toward that end.

Supporters of AOT also rely on the “black robe effect,” stating that individuals currently not engaged in services will engage if presented with a court order and a judge’s involvement. As was noted by a member of the probation team, this belief relies on an idea that individuals with SPMI make rational decisions about their treatment. It is the experience of many individuals working with the SPMI population that decisions are more often made impulsively and without true regard for consequences. The experience within Stanislaus County with current mental health programs that involve a court mandate, such as the mental health court, show that individuals do not routinely follow the court orders for treatment. The lack of evidentiary support for the black robe effect in the literature provides insufficient evidence to support AOT implementation at this time.

County comparison. County implementations of AOT vary widely, which makes it difficult to discern the fiscal impact of AOT implementation for Stanislaus County. Fiscal impacts in a given location are highly dependent upon the specifics of the county’s implementation decisions, including staffing, structure of contracting, availability of resources and breadth of services offered. Additionally, many implementations in California are new, having started in the last 12-24 months. These newer implementations have not yet released robust fiscal data, limiting the sample size of county fiscal data available to extrapolate to Stanislaus County.

Similarly, clinical outcomes vary widely by county due to the wide variation in implementation strategies utilized. These variations, in addition to the infancy of most AOT implementations and the small sample sizes of court ordered individuals in each county, limit our ability to state unequivocally that the AOT program will improve the lives of SPMI consumers in Stanislaus more than high fidelity ACT.

System of Care analysis. BHRS is currently working on several behavioral health initiatives that aim to improve access and quality of treatment for SPMI consumers. These initiatives include implementation of Individual Placement and Support (IPS) supported employment and increasing fidelity of ACT services. It is our belief that these initiatives represent a better effort to improve the lives of SPMI consumers and to increase engagement into services for those individuals currently not enrolled in services.

In addition to continuing these initiatives, we recommend that BHRS develop a specialized SPMI engagement team to reinforce their ability to robustly engage individuals in care. This should include a family referral hotline, which provides family members with a single point of access through which they can identify a consumer in need of services and to whom BHRS staff can target engagement activities. This is, in our opinion, one of the most powerful aspects of Laura's Law, as it would enhance engagement for those whom it is challenging to reach and it would provide families and other community members the ability to bring individuals to the county's attention that may be in need of mental health services.

RECOMMENDATIONS

We believe that many of the benefits that are listed above as reasons to implement Laura's Law could be achieved by the county through other means. Additionally, the current evidence of positive consumer outcomes and fiscal benefits of California AOT implementation is not robust. However, there is considerable public support for implementation of Laura's Law in Stanislaus County, and some initial anecdotal evidence from other California counties that its implementation may improve outcomes for those individuals who have refused other avenues for treatment.

Regardless of the final decision reached by the Stanislaus Board of Supervisors regarding Laura's Law implementation, it is our recommendation that BHRS expand and enhance their FSP programs, utilizing a structured ACT model, by adding FSP staff and adjusting the programs as necessary to ensure fidelity with the ACT approach. More individuals should be enrolled in FSP programs and intensive services should be provided to each consumer using a 1:10 staff to consumer ratio. ACT, when implemented with fidelity, shows strong evidence that it improves outcomes in precisely the areas that family advocates hope for, reducing incarceration, hospitalization and homelessness while increasing engagement in mental health services. Robust continuous quality improvement practices would be required to ensure that the enhanced services lead to the clinical outcomes desired by BHRS.

Table 10 below provides a summary of priorities for BHRS to consider, as well as actions recommended by The Results Group to strengthen the current systems of care and address concerns of family advocates and other community members.

TABLE 10 - PRIORITIES AND RECOMMENDED ACTIONS

Priority	Recommended Actions
Engage and treat high-need consumers currently not engaged or poorly engaged in treatment	<ol style="list-style-type: none"> 1. Create SPMI engagement team focused on strong, collaborative engagement where consumers are located in the community 2. Implement family hotline to assist in identifying individuals in need of services that are not currently connected to BHRS
Increase fidelity of ACT practices	<ol style="list-style-type: none"> 1. Develop a new position for evidence-based practices training and fidelity monitoring to ensure close adherence of FSP teams to ACT model 2. Re-train all FSP staff in ACT model to develop fidelity to current ACT practices 3. Hire additional FSP staff to reduce staff to consumer ratio to ACT appropriate levels (1:10) 4. Identify other evidence-based practices in need of similar efforts to improve fidelity
Improve housing assistance and placement capacity	<ol style="list-style-type: none"> 1. Continue efforts to purchase additional supported housing 2. Develop review protocol for board and care or other residential facilities receiving county funds in order to improve quality of care
Increase vocational assistance using evidence-based practices	<ol style="list-style-type: none"> 1. Implement IPS supported employment program pilot program 2. Review pilot data for program efficacy and fully implement if data reflects positive outcomes for consumers 3. Collaborate with qualified jurisdictions who have successfully implemented robust employment programs for SPMI consumers
Increase education to community	<ol style="list-style-type: none"> 1. Develop a community educational campaign that focuses on informing individuals about current services offered by BHRS and methods to access care for self or a loved one 2. Hold community forums in collaboration with NAMI to increase knowledge of family members and consumers regarding services available to SPMI adults across BHRS

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Family advocacy	<ol style="list-style-type: none">1. Add family advocate position to each FSP team or centrally at BHRS2. Continue to develop a close and collaborative relationship with NAMI Stanislaus3. Institute family hotline for referral of loved ones to BHRS services
Consumer stakeholder engagement	<ol style="list-style-type: none">1. Build consumer engagement and advocacy groups to assist in advising BHRS on the needs of the Stanislaus consumer population2. Ensure that consumer engagement and advocacy groups are represented at all levels of BHRS, at community forums and at key decision making meetings

We recommend that the decision around full implementation of Laura's Law be revisited after BHRS implements the above recommendations and collects meaningful data to determine the efficacy these efforts in engaging consumers, reducing use of high-end mental health services and improving outcomes for SPMI consumers. Should the above recommendations not create the levels of engagement, high quality services and positive outcomes we anticipate, BHRS may want to complete a full system evaluation and identify additional interventions or improved implementation strategies that could assist consumers.

ADDITIONAL OPTION FOR CONSIDERATION

The Board of Supervisors may also consider an initial three-year pilot of Laura's Law (AB 1421), which includes a rigorous evaluation that compares outcomes for individuals receiving an AOT court order to those receiving voluntary ACT services within the system of care. BHRS would be encouraged to leverage existing resources and design the necessary research and evaluation components to ensure that information obtained throughout the pilot will be useful in making a determination about AOT efficacy at the end of the pilot period.

Under this option, the Director would convene a work group that would include BHRS, community partners, consumers, family members and advocacy organizations to design the Evaluation Pilot. The Director would collaborate with the workgroup, and develop implementation strategies, cost and budget estimates for the Board of Supervisors to consider.

APPENDIX A – TEXT OF AB 1421



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AB-1421 Mental health: involuntary treatment. (2001-2002)

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Assembly Bill No. 1421

CHAPTER 1017

An act to add and repeal Article 9 (commencing with Section 5345) of Chapter 2 of Part 1 of Division 5 of the Welfare and Institutions Code, relating to mental health.

[Filed with Secretary of State September 28, 2002. Approved by Governor September 28, 2002.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1421, Thomson. Mental health: involuntary treatment.

Existing law, the Lanterman-Petris-Short Act, makes provision for the involuntary treatment of any person with a mental disorder who, as a result of the mental disorder, is a danger to others or to himself or herself, or is gravely disabled.

This bill, until January 1, 2008, would enact the Assisted Outpatient Treatment Demonstration Project Act of 2002, which would create an assisted outpatient treatment program for any person who is suffering from a mental disorder and meets certain criteria. The program would operate in counties that choose to provide the services.

The program would involve the delivery of community-based care by multidisciplinary teams of highly trained mental health professionals with staff-to-client ratios of not more than 1 to 10, and additional services, as specified, for persons with the most persistent and severe mental illness.

This bill would specify requirements for the petition alleging the necessity of treatment, various rights of the person who is the subject of the petition, and hearing procedures. This bill would also provide for settlement agreements as an alternative to the hearing process. This bill would provide that if the person who is the subject of the petition fails to comply with outpatient treatment, despite efforts to solicit compliance, a licensed mental health treatment provider may request that the person be placed under a 72-hour hold based on an involuntary commitment.

This bill would also require each county operating an outpatient treatment program pursuant to the bill to provide certain data to the State Department of Mental Health, and would impose requirements upon the department to report to the Legislature, as specified.

The bill would also require the department to develop a specified training and education program for use in counties participating in the program pursuant to the bill.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature finds and declares all of the following:

- (a) On February 15, 2001, the Rand Corporation released a report, commissioned by the California Senate Committee on Rules, titled "The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States," which is an

evidence-based approach to examining and synthesizing empirical research on involuntary outpatient treatment.

(b) Rand's findings include the following:

(1) Data from the State Department of Mental Health's Client Data System, documenting about one-half of all commitments in California, indicate that 58,439 individuals accounted for 106,314 admissions under 72-hour holds, and, of those:

(A) Thirty-three and two-tenths percent, or 17,062, had at least one prior episode of involuntary commitment in the previous 12 months.

(B) Thirty-four and three-tenths percent, or 17,627, lived with a family member prior to the hold.

(C) Thirty-four and three-tenths percent, or 17,627, had a diagnosis of schizophrenia or other psychosis.

(D) Thirty-seven and two-tenths percent, or 19,118, had no record of outpatient service use in the previous 12 months.

(2) Some high-risk patients do not respond well to traditional community-based mental health services. For various reasons, even when treatment is made available, high-risk patients do not avail themselves of these services.

(3) In general, these ambulatory care data from the department's client data system do not support the assumption that individuals were entering the involuntary treatment system because they were not able to access outpatient services.

(4) The best evidence from randomized clinical trials supports the use of assertive community treatment (ACT) programs, which involve the delivery of community-based care by multidisciplinary teams of highly trained mental health professionals with high staff-to-client ratios. The evidence also suggests that fidelity to the ACT model ensures better client outcomes.

(5) A study by Duke University investigators, using randomized clinical trials, suggests that people with psychotic disorders and those at highest risk for poor outcomes benefit from intensive mental health services provided in concert with a sustained outpatient commitment order.

(6) The effect of sustained outpatient commitment, according to the Duke study, was particularly strong for people with schizophrenia and other psychotic disorders. When patients with these disorders were on outpatient commitment for an extended period of 180 days or more, and also received intensive mental health services, they had 72 percent fewer readmissions to the hospital and 28 fewer hospital days than the non-outpatient commitment group.

SEC. 2. Article 9 (commencing with Section 5345) is added to Chapter 2 of Part 1 of Division 5 of the Welfare and Institutions Code, to read:

Article 9. The Assisted Outpatient Treatment Demonstration Project Act of 2002

5345. (a) This article shall be known, and may be cited, as Laura's Law.

(b) "Assisted outpatient treatment" shall be defined as categories of outpatient services that have been ordered by a court pursuant to Section 5346 or 5347.

5346. (a) In any county in which services are available as provided in Section 5348, a court may order a person who is the subject of a petition filed pursuant to this section to obtain assisted outpatient treatment if the court finds, by clear and convincing evidence, that the facts stated in the verified petition filed in accordance with this section are true and establish that all of the requisite criteria set forth in this section are met, including, but not limited to, each of the following:

- (1) The person is 18 years of age or older.
 - (2) The person is suffering from a mental illness as defined in paragraphs (2) and (3) of subdivision (b) of Section 5600.3.
 - (3) There has been a clinical determination that the person is unlikely to survive safely in the community without supervision.
 - (4) The person has a history of lack of compliance with treatment for his or her mental illness, in that at least one of the following is true:
 - (A) The person's mental illness has, at least twice within the last 36 months, been a substantial factor in necessitating hospitalization, or receipt of services in a forensic or other mental health unit of a state correctional facility or local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition.
 - (B) The person's mental illness has resulted in one or more acts of serious and violent behavior toward himself or herself or another, or threats, or attempts to cause serious physical harm to himself or herself or another within the last 48 months, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition.
 - (5) The person has been offered an opportunity to participate in a treatment plan by the director of the local mental health department, or his or her designee, provided the treatment plan includes all of the services described in Section 5348, and the person continues to fail to engage in treatment.
 - (6) The person's condition is substantially deteriorating.
 - (7) Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure the person's recovery and stability.
 - (8) In view of the person's treatment history and current behavior, 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 himself or herself, or to others, as defined in Section 5150.
 - (9) It is likely that the person will benefit from assisted outpatient treatment.
- (b) (1) A petition for an order authorizing assisted outpatient treatment may be filed by the county mental health director, or his or her designee, in the superior court in the county in which the person who is the subject of the petition is present or reasonably believed to be present.
- (2) A request may be made only by any of the following persons to the county mental health department for the filing of a petition to obtain an order authorizing assisted outpatient treatment:
- (A) Any person 18 years of age or older with whom the person who is the subject of the petition resides.

- (B) Any person who is the parent, spouse, or sibling or child 18 years of age or older of the person who is the subject of the petition.
 - (C) The director of any public or private agency, treatment facility, charitable organization, or licensed residential care facility providing mental health services to the person who is the subject of the petition in whose institution the subject of the petition resides.
 - (D) The director of a hospital in which the person who is the subject of the petition is hospitalized.
 - (E) A licensed mental health treatment provider who is either supervising the treatment of, or treating for a mental illness, the person who is the subject of the petition.
 - (F) A peace officer, parole officer, or probation officer assigned to supervise the person who is the subject of the petition.
- (3) Upon receiving a request pursuant to paragraph (2), the county mental health director shall conduct an investigation into the appropriateness of the filing of the petition. The director shall file the petition only if he or she determines that there is a reasonable likelihood that all the necessary elements to sustain the petition can be proven in a court of law by clear and convincing evidence.
- (4) The petition shall state all of the following:
- (A) Each of the criteria for assisted outpatient treatment as set forth in subdivision (a).
 - (B) Facts that support the petitioner's belief that the person who is the subject of the petition meets each criterion, provided that the hearing on the petition shall be limited to the stated facts in the verified petition, and the petition contains all the grounds on which the petition is based, in order to ensure adequate notice to the person who is the subject of the petition and his or her counsel.
 - (C) That the person who is the subject of the petition is present, or is reasonably believed to be present, within the county where the petition is filed.
 - (D) That the person who is the subject of the petition has the right to be represented by counsel in all stages of the proceeding under the petition, in accordance with subdivision (c).
- (5) The petition shall be accompanied by an affidavit of a licensed mental health treatment provider designated by the local mental health director who shall state, if applicable, either of the following:
- (A) That the licensed mental health treatment provider has personally examined the person who is the subject of the petition no more than 10 days prior to the submission of the petition, the facts and reasons why the person who is the subject of the petition meets the criteria in subdivision (a), that the licensed mental health treatment provider recommends assisted outpatient treatment for the person who is the subject of the petition, and that the licensed mental health treatment provider is willing and able to testify at the hearing on the petition.
 - (B) That no more than 10 days prior to the filing of the petition, the licensed mental health treatment provider, or his or her designee, has made appropriate attempts to elicit the cooperation of the person who is the subject of the petition, but has not been successful in persuading that person to submit to an examination, that the licensed mental health treatment provider has reason to believe that the person who is the subject of the petition meets the

criteria for assisted outpatient treatment, and that the licensed mental health treatment provider is willing and able to examine the person who is the subject of the petition and testify at the hearing on the petition.

(c) The person who is the subject of the petition shall have the right to be represented by counsel at all stages of a proceeding commenced under this section. If the person so elects, the court shall immediately appoint the public defender or other attorney to assist the person in all stages of the proceedings. The person shall pay the cost of the legal services if he or she is able.

(d) (1) Upon receipt by the court of a petition submitted pursuant to subdivision (b), the court shall fix the date for a hearing at a time not later than five days from the date the petition is received by the court, excluding Saturdays, Sundays, and holidays. The petitioner shall promptly cause service of a copy of the petition, together with written notice of the hearing date, to be made personally on the person who is the subject of the petition, and shall send a copy of the petition and notice to the county office of patient rights, and to the current health care provider appointed for the person who is the subject of the petition, if any such provider is known to the petitioner. Continuances shall be permitted only for good cause shown. In granting continuances, the court shall consider the need for further examination by a physician or the potential need to provide expeditiously assisted outpatient treatment. Upon the hearing date, or upon any other date or dates to which the proceeding may be continued, the court shall hear testimony. If it is deemed advisable by the court, and if the person who is the subject of the petition is available and has received notice pursuant to this section, the court may examine in or out of court the person who is the subject of the petition who is alleged to be in need of assisted outpatient treatment. If the person who is the subject of the petition does not appear at the hearing, and appropriate attempts to elicit the attendance of the person have failed, the court may conduct the hearing in the person's absence. If the hearing is conducted without the person present, the court shall set forth the factual basis for conducting the hearing without the person's presence.

(2) The court shall not order assisted outpatient treatment unless an examining licensed mental health treatment provider, who has personally examined, and has reviewed the available treatment history of, the person who is the subject of the petition within the time period commencing 10 days before the filing of the petition, testifies in person at the hearing.

(3) If the person who is the subject of the petition has refused to be examined by a licensed mental health treatment provider, the court may request that the person consent to an examination by a licensed mental health treatment provider appointed by the court. If the person who is the subject of the petition does not consent and the court finds reasonable cause to believe that the allegations in the petition are true, the court may order any person designated under Section 5150 to take into custody the person who is the subject of the petition and transport him or her, or cause him or her to be transported, to a hospital for examination by a licensed mental health treatment provider as soon as is practicable. Detention of the person who is the subject of the petition under the order may not exceed 72 hours. If the examination is performed by another licensed mental health treatment provider, the examining licensed mental health treatment provider may consult with the

licensed mental health treatment provider whose affirmation or affidavit accompanied the petition regarding the issues of whether the allegations in the petition are true and whether the person meets the criteria for assisted outpatient treatment.

(4) The person who is the subject of the petition shall have all of the following rights:

(A) To adequate notice of the hearings to the person who is the subject of the petition, as well as to parties designated by the person who is the subject of the petition.

(B) To receive a copy of the court-ordered evaluation.

(C) To counsel. If the person has not retained counsel, the court shall appoint a public defender.

(D) To be informed of his or her right to judicial review by habeas corpus.

(E) To be present at the hearing unless he or she waives the right to be present.

(F) To present evidence.

(G) To call witnesses on his or her behalf.

(H) To cross-examine witnesses.

(I) To appeal decisions, and to be informed of his or her right to appeal.

(5) (A) If after hearing all relevant evidence, the court finds that the person who is the subject of the petition does not meet the criteria for assisted outpatient treatment, the court shall dismiss the petition.

(B) If after hearing all relevant evidence, the court finds that the person who is the subject of the petition meets the criteria for assisted outpatient treatment, and there is no appropriate and feasible less restrictive alternative, the court may order the person who is the subject of the petition to receive assisted outpatient treatment for an initial period not to exceed six months. In fashioning the order, the court shall specify that the proposed treatment is the least restrictive treatment appropriate and feasible for the person who is the subject of the petition. The order shall state the categories of assisted outpatient treatment, as set forth in Section 5348, that the person who is the subject of the petition is to receive, and the court may not order treatment that has not been recommended by the examining licensed mental health treatment provider and included in the written treatment plan for assisted outpatient treatment as required by subdivision (e).

If the person has executed an advance health care directive pursuant to Chapter 2 (commencing with Section 4650) of Part 1 of Division 4.7 of the Probate Code, any directions included in the advance health care directive shall be considered in formulating the written treatment plan.

(6) If the person who is the subject of a petition for an order for assisted outpatient treatment pursuant to subparagraph (B) of paragraph (5) of subdivision (d) refuses to participate in the assisted outpatient treatment program, the court may order the person to meet with the assisted outpatient treatment team designated by the director of the assisted outpatient treatment program. The treatment team shall attempt to gain the person's cooperation with treatment ordered by the court. The person may be subject to a 72-hour hold pursuant to subdivision (f) only after the treatment team has attempted to gain the person's cooperation with treatment ordered by the court, and has been unable to do so.

(e) Assisted outpatient treatment shall not be ordered unless the licensed mental health treatment provider recommending assisted outpatient treatment to the court has submitted to the court a

written treatment plan that includes services as set forth in Section 5348, and the court finds, in consultation with the county mental health director, or his or her designee, all of the following:

- (1) That the services are available from the county, or a provider approved by the county, for the duration of the court order.
 - (2) That the services have been offered to the person by the local director of mental health, or his or her designee, and the person has been given an opportunity to participate on a voluntary basis, and the person has failed to engage in, or has refused, treatment.
 - (3) That all of elements of the petition required by this article have been met.
 - (4) That the treatment plan will be delivered to the county director of mental health, or to his or her appropriate designee.
- (f) If, in the clinical judgment of a licensed mental health treatment provider, the person who is the subject of the petition has failed or has refused to comply with the treatment ordered by the court, and, in the clinical judgment of the licensed mental health treatment provider, efforts were made to solicit compliance, and, in the clinical judgment of the licensed mental health treatment provider, the person may be in need of involuntary admission to a hospital for evaluation, the provider may request that persons designated under Section 5150 take into custody the person who is the subject of the petition and transport him or her, or cause him or her to be transported, to a hospital, to be held up to 72 hours for examination by a licensed mental health treatment provider to determine if the person is in need of treatment pursuant to Section 5150. Any continued involuntary retention in a hospital beyond the initial 72-hour period shall be pursuant to Section 5150. If at any time during the 72-hour period the person is determined not to meet the criteria of Section 5150, and does not agree to stay in the hospital as a voluntary patient, he or she shall be released and any subsequent involuntary detention in a hospital shall be pursuant to Section 5150. Failure to comply with an order of assisted outpatient treatment alone may not be grounds for involuntary civil commitment or a finding that the person who is the subject of the petition is in contempt of court.
- (g) If the director of the assisted outpatient treatment program determines that the condition of the patient requires further assisted outpatient treatment, the director shall apply to the court, prior to the expiration of the period of the initial assisted outpatient treatment order, for an order authorizing continued assisted outpatient treatment for a period not to exceed 180 days from the date of the order. The procedures for obtaining any order pursuant to this subdivision shall be in accordance with subdivisions (a) to (f), inclusive. The period for further involuntary outpatient treatment authorized by any subsequent order under this subdivision may not exceed 180 days from the date of the order.
- (h) At intervals of not less than 60 days during an assisted outpatient treatment order, the director of the outpatient treatment program shall file an affidavit with the court that ordered the outpatient treatment affirming that the person who is the subject of the order continues to meet the criteria for assisted outpatient treatment. At these times, the person who is the subject of the order shall have the right to a hearing on whether or not he or she still meets the criteria for assisted outpatient treatment if he or she disagrees with the director's affidavit. The burden of proof shall be on the director.

(i) During each 60-day period specified in subdivision (h), if the person who is the subject of the order believes that he or she is being wrongfully retained in the assisted outpatient treatment program against his or her wishes, he or she may file a petition for a writ of habeas corpus, thus requiring the director of the assisted outpatient treatment program to prove that the person who is the subject of the order continues to meet the criteria for assisted outpatient treatment.

(j) Any person ordered to undergo assisted outpatient treatment pursuant to this article, who was not present at the hearing at which the order was issued, may immediately petition the court for a writ of habeas corpus. Treatment under the order for assisted outpatient treatment may not commence until the resolution of that petition.

5347. (a) In any county in which services are available pursuant to Section 5348, any person who is determined by the court to be subject to subdivision (a) of Section 5346 may voluntarily enter into an agreement for services under this section.

(b) (1) After a petition for an order for assisted outpatient treatment is filed, but before the conclusion of the hearing on the petition, the person who is the subject of the petition, or the person's legal counsel with the person's consent, may waive the right to an assisted outpatient treatment hearing for the purpose of obtaining treatment under a settlement agreement, provided that an examining licensed mental health treatment provider states that the person can survive safely in the community. The settlement agreement may not exceed 180 days in duration and shall be agreed to by all parties.

(2) The settlement agreement shall be in writing, shall be approved by the court, and shall include a treatment plan developed by the community-based program that will provide services that provide treatment in the least restrictive manner consistent with the needs of the person who is the subject of the petition.

(3) Either party may request that the court modify the treatment plan at any time during the 180-day period.

(4) The court shall designate the appropriate county department to monitor the person's treatment under, and compliance with, the settlement agreement. If the person fails to comply with the treatment according to the agreement, the designated county department shall notify the counsel designated by the county and the person's counsel of the person's noncompliance.

(5) A settlement agreement approved by the court pursuant to this section shall have the same force and effect as an order for assisted outpatient treatment pursuant to Section 5346.

(6) At a hearing on the issue of noncompliance with the agreement, the written statement of noncompliance submitted shall be prima facie evidence that a violation of the conditions of the agreement has occurred. If the person who is the subject of the petition denies any of the facts as stated in the statement, he or she has the burden of proving by a preponderance of the evidence that the alleged facts are false.

5348. (a) For purposes of subdivision (e) of Section 5346, any county that chooses to provide assisted outpatient treatment services pursuant to this article shall offer assisted outpatient treatment services including, but not limited to, all of the following:

- (1) Community-based, mobile, multidisciplinary, highly trained mental health teams that use high staff-to-client ratios of no more than 10 clients per team member for those subject to court-ordered services pursuant to Section 5346.
- (2) A service planning and delivery process that includes the following:
 - (A) Determination of the numbers of persons to be served and the programs and services that will be provided to meet their needs. The local director of mental health shall consult with the sheriff, the police chief, the probation officer, the mental health board, contract agencies, and family, client, ethnic, and citizen constituency groups as determined by the director.
 - (B) Plans for services, including outreach to families whose severely mentally ill adult is living with them, design of mental health services, coordination and access to medications, psychiatric and psychological services, substance abuse services, supportive housing or other housing assistance, vocational rehabilitation, and veterans' services. Plans shall also contain evaluation strategies, that shall consider cultural, linguistic, gender, age, and special needs of minorities in the target populations. Provision shall be made for staff with the cultural background and linguistic skills necessary to remove barriers to mental health services as a result of having limited-English-speaking ability and cultural differences. Recipients of outreach services may include families, the public, primary care physicians, and others who are likely to come into contact with individuals who may be suffering from an untreated severe mental illness who would be likely to become homeless if the illness continued to be untreated for a substantial period of time. Outreach to adults may include adults voluntarily or involuntarily hospitalized as a result of a severe mental illness.
 - (C) Provisions for services to meet the needs of persons who are physically disabled.
 - (D) Provision for services to meet the special needs of older adults.
 - (E) Provision for family support and consultation services, parenting support and consultation services, and peer support or self-help group support, where appropriate.
 - (F) Provision for services to be client-directed and that employ psychosocial rehabilitation and recovery principles.
 - (G) Provision for psychiatric and psychological services that are integrated with other services and for psychiatric and psychological collaboration in overall service planning.
 - (H) Provision for services specifically directed to seriously mentally ill young adults 25 years of age or younger who are homeless or at significant risk of becoming homeless. These provisions may include continuation of services that would still be received through other funds had eligibility not been terminated as a result of age.
 - (I) Services reflecting special needs of women from diverse cultural backgrounds, including supportive housing that accepts children, personal services coordinator therapeutic treatment, and substance treatment programs that address gender specific trauma and abuse in the lives of persons with mental illness, and vocational rehabilitation programs that offer job training programs free of gender bias and sensitive to the needs of women.
 - (J) Provision for housing for clients that is immediate, transitional, permanent, or all of these.

(K) Provision for clients who have been suffering from an untreated severe mental illness for less than one year, and who do not require the full range of services, but are at risk of becoming homeless unless a comprehensive individual and family support services plan is implemented. These clients shall be served in a manner that is designed to meet their needs.

(3) Each client shall have a clearly designated mental health personal services coordinator who may be part of a multidisciplinary treatment team who is responsible for providing or assuring needed services. Responsibilities include complete assessment of the client's needs, development of the client's personal services plan, linkage with all appropriate community services, monitoring of the quality and follow through of services, and necessary advocacy to ensure each client receives those services which are agreed to in the personal services plan. Each client shall participate in the development of his or her personal services plan, and responsible staff shall consult with the designated conservator, if one has been appointed, and, with the consent of the client, shall consult with the family and other significant persons as appropriate.

(4) The individual personal services plan shall ensure that persons subject to assisted outpatient treatment programs receive age, gender, and culturally appropriate services, to the extent feasible, that are designed to enable recipients to:

- (A) Live in the most independent, least restrictive housing feasible in the local community, and, for clients with children, to live in a supportive housing environment that strives for reunification with their children or assists clients in maintaining custody of their children as is appropriate.
- (B) Engage in the highest level of work or productive activity appropriate to their abilities and experience.
- (C) Create and maintain a support system consisting of friends, family, and participation in community activities.
- (D) Access an appropriate level of academic education or vocational training.
- (E) Obtain an adequate income.
- (F) Self-manage their illnesses and exert as much control as possible over both the day-to-day and long-term decisions that affect their lives.
- (G) Access necessary physical health care and maintain the best possible physical health.
- (H) Reduce or eliminate serious antisocial or criminal behavior, and thereby reduce or eliminate their contact with the criminal justice system.
- (I) Reduce or eliminate the distress caused by the symptoms of mental illness.
- (J) Have freedom from dangerous addictive substances.

(5) The individual personal services plan shall describe the service array that meets the requirements of paragraph (4), and to the extent applicable to the individual, the requirements of paragraph (2).

(b) Any county that provides assisted outpatient treatment services pursuant to this article also shall offer the same services on a voluntary basis.

(c) Involuntary medication shall not be allowed absent a separate order by the court pursuant to Sections 5332 to 5336, inclusive.

- (d) Each county that operates an assisted outpatient treatment program pursuant to this article shall provide data to the State Department of Mental Health and, based on the data, the department shall report to the Legislature on or before May 1 of each year in which the county provides services pursuant to this article. The report shall include, at a minimum, an evaluation of the effectiveness of the strategies employed by each program operated pursuant to this article in reducing homelessness and hospitalization of persons in the program and in reducing involvement with local law enforcement by persons in the program. The evaluation and report shall also include any other measures identified by the department regarding persons in the program and all of the following, based on information that is available:
- (e) (1) The number of persons served by the program and, of those, the number who are able to maintain housing and the number who maintain contact with the treatment system.
 - (f) (2) The number of persons in the program with contacts with local law enforcement, and the extent to which local and state incarceration of persons in the program has been reduced or avoided.
 - (g) (3) The number of persons in the program participating in employment services programs, including competitive employment.
 - (h) (4) The days of hospitalization of persons in the program that have been reduced or avoided.
 - (i) (5) Adherence to prescribed treatment by persons in the program.
 - (j) (6) Other indicators of successful engagement, if any, by persons in the program.
 - (k) (7) Victimization of persons in the program.
 - (l) (8) Violent behavior of persons in the program.
 - (m) (9) Substance abuse by persons in the program.
 - (n) (10) Type, intensity, and frequency of treatment of persons in the program.
 - (o) (11) Extent to which enforcement mechanisms are used by the program, when applicable.
 - (p) (12) Social functioning of persons in the program.
 - (q) (13) Skills in independent living of persons in the program.
 - (r) (14) Satisfaction with program services both by those receiving them and by their families, when relevant.

(S) **5349.**

(t) This article shall be operative in those counties in which the county board of supervisors, by resolution, authorizes its application and makes a finding that no voluntary mental health program serving adults, and no children's mental health program, may be reduced as a result of the implementation of this article. Compliance with this section shall be monitored by the State Department of Mental Health as part of its review and approval of county Short-Doyle plans.

(U) **5349.1.**

(v) (a) Counties that elect to implement this article, shall, in consultation with the department, client and family advocacy organizations, and other stakeholders, develop a training and education program for purposes of improving the delivery of services to mentally ill individuals who are, or who are at risk of being, involuntarily committed under this part. This

training shall be provided to mental health treatment providers contracting with participating counties and to other individuals, including, but not limited to, mental health professionals, law enforcement officials, and certification hearing officers involved in making treatment and involuntary commitment decisions.

- (w) (b) The training shall include both of the following:
- (x) (1) Information relative to legal requirements for detaining a person for involuntary inpatient and outpatient treatment, including criteria to be considered with respect to determining if a person is considered to be gravely disabled.
- (y) (2) Methods for ensuring that decisions regarding involuntary treatment as provided for in this part direct patients toward the most effective treatment. Training shall include an emphasis on each patient's right to provide informed consent to assistance.
- (z)



APPENDIX B – TEXT OF AB 59



Home	Bill	California	Publication	Other Resource	My	My
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AB-59 Mental health services: assisted outpatient treatment. (2015-2016)

SHARE THIS:

Assembly Bill No. 59

CHAPTER 251

An act to amend Sections 5348 and 5349.5 of the Welfare and Institutions Code, relating to mental health services, and making an appropriation therefor.

[Approved by Governor September 09, 2016. Filed with Secretary of State September 09, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

AB 59, Waldron. Mental health services: assisted outpatient treatment.

Existing law, the Assisted Outpatient Treatment Demonstration Project Act of 2002, known as Laura's Law, until January 1, 2017, grants each county the authority to offer certain assisted outpatient treatment services for their residents by adoption of a resolution or through the county budget process and by making a finding that no mental health program, as specified, may be reduced as a result of implementation. Under that law, participating counties are required to provide prescribed assisted outpatient services, including a service planning and delivery process, that are client-directed and employ psychosocial rehabilitation and recovery principles. Existing law authorizes participating counties to pay for the services provided from moneys distributed to the counties from various continuously appropriated funds, including the Local Revenue Fund and the Mental Health Services Fund when included in a county plan, as specified. Existing law requires the State Department of Health Care Services to submit a report and evaluation of all counties implementing any component of these provisions to the Governor and the Legislature by July 1, 2015.

This bill would extend the operation of the program until January 1, 2022, and would delete that reporting requirement. By extending the authorization to pay for the services using moneys from various continuously appropriated funds, the bill would make an appropriation.

Existing law requires a county that operates an assisted outpatient treatment program pursuant to these provisions to provide data to the department, and requires the department to report to the Legislature on or before May 1 of each year based on that data, as specified.

This bill would additionally require the department to report that information to the Governor.

Vote: majority Appropriation: yes Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 5348 of the Welfare and Institutions Code is amended to read:

5348. (a) For purposes of subdivision (e) of Section 5346, a county that chooses to provide assisted outpatient treatment services pursuant to this article shall offer assisted outpatient treatment services including, but not limited to, all of the following:

- (1) Community-based, mobile, multidisciplinary, highly trained mental health teams that use high staff-to-client ratios of no more than 10 clients per team member for those subject to court-ordered services pursuant to Section 5346.
- (2) A service planning and delivery process that includes the following:
 - (A) Determination of the numbers of persons to be served and the programs and services that will be provided to meet their needs. The local director of mental health shall consult with the sheriff, the police chief, the probation officer, the mental health board, contract agencies, and family, client, ethnic, and citizen constituency groups as determined by the director.
 - (B) Plans for services, including outreach to families whose severely mentally ill adult is living with them, design of mental health services, coordination and access to medications, psychiatric and psychological services, substance abuse services, supportive housing or other housing assistance, vocational rehabilitation, and veterans' services. Plans shall also contain evaluation strategies, which shall consider cultural, linguistic, gender, age, and special needs of minorities and those based on any characteristic listed or defined in Section 11135 of the Government Code in the target populations. Provision shall be made for staff with the cultural background and linguistic skills necessary to remove barriers to mental health services as a result of having limited-English speaking ability and cultural differences. Recipients of outreach services may include families, the public, primary care physicians, and others who are likely to come into contact with individuals who may be suffering from an untreated severe mental illness who would be likely to become homeless if the illness continued to be untreated for a substantial period of time. Outreach to adults may include adults voluntarily or involuntarily hospitalized as a result of a severe mental illness.
 - (C) Provision for services to meet the needs of persons who are physically disabled.
 - (D) Provision for services to meet the special needs of older adults.
 - (E) Provision for family support and consultation services, parenting support and consultation services, and peer support or self-help group support, if appropriate.
 - (F) Provision for services to be client-directed and to employ psychosocial rehabilitation and recovery principles.
 - (G) Provision for psychiatric and psychological services that are integrated with other services and for psychiatric and psychological collaboration in overall service planning.
 - (H) Provision for services specifically directed to seriously mentally ill young adults 25 years of age or younger who are homeless or at significant risk of becoming homeless. These provisions may include continuation of services that still would be received through other funds had eligibility not been terminated as a result of age.
 - (I) Services reflecting special needs of women from diverse cultural backgrounds, including supportive housing that accepts children, personal services coordinator therapeutic treatment, and substance treatment programs that address gender-specific trauma and abuse in the lives of persons with mental illness, and vocational rehabilitation programs that offer job training programs free of gender bias and sensitive to the needs of women.

- (J) Provision for housing for clients that is immediate, transitional, permanent, or all of these.
- (K) Provision for clients who have been suffering from an untreated severe mental illness for less than one year, and who do not require the full range of services, but who are at risk of becoming homeless unless a comprehensive individual and family support services plan is implemented. These clients shall be served in a manner that is designed to meet their needs.
- (3) Each client shall have a clearly designated mental health personal services coordinator who may be part of a multidisciplinary treatment team that is responsible for providing or assuring needed services. Responsibilities include complete assessment of the client's needs, development of the client's personal services plan, linkage with all appropriate community services, monitoring of the quality and follow-through of services, and necessary advocacy to ensure each client receives those services that are agreed to in the personal services plan. Each client shall participate in the development of his or her personal services plan, and responsible staff shall consult with the designated conservator, if one has been appointed, and, with the consent of the client, shall consult with the family and other significant persons as appropriate.
- (4) The individual personal services plan shall ensure that persons subject to assisted outpatient treatment programs receive age-appropriate, gender-appropriate, and culturally appropriate services, to the extent feasible, that are designed to enable recipients to:
 - (A) Live in the most independent, least restrictive housing feasible in the local community, and, for clients with children, to live in a supportive housing environment that strives for reunification with their children or assists clients in maintaining custody of their children as is appropriate.
 - (B) Engage in the highest level of work or productive activity appropriate to their abilities and experience.
 - (C) Create and maintain a support system consisting of friends, family, and participation in community activities.
 - (D) Access an appropriate level of academic education or vocational training.
 - (E) Obtain an adequate income.
 - (F) Self-manage their illnesses and exert as much control as possible over both the day-to-day and long-term decisions that affect their lives.
 - (G) Access necessary physical health care and maintain the best possible physical health.
 - (H) Reduce or eliminate serious antisocial or criminal behavior, and thereby reduce or eliminate their contact with the criminal justice system.
 - (I) Reduce or eliminate the distress caused by the symptoms of mental illness.
 - (J) Have freedom from dangerous addictive substances.
- (5) The individual personal services plan shall describe the service array that meets the requirements of paragraph (4), and to the extent applicable to the individual, the requirements of paragraph (2).
- (b) A county that provides assisted outpatient treatment services pursuant to this article also shall offer the same services on a voluntary basis.

(c) Involuntary medication shall not be allowed absent a separate order by the court pursuant to Sections 5332 to 5336, inclusive.

(d) A county that operates an assisted outpatient treatment program pursuant to this article shall provide data to the State Department of Health Care Services and, based on the data, the department shall report to the Governor and the Legislature on or before May 1 of each year regarding the services the county provides pursuant to this article. The report shall include, at a minimum, an evaluation of the effectiveness of the strategies employed by each program operated pursuant to this article in reducing homelessness and hospitalization of persons in the program and in reducing involvement with local law enforcement by persons in the program. The evaluation and report shall also include any other measures identified by the department regarding persons in the program and all of the following, based on information that is available:

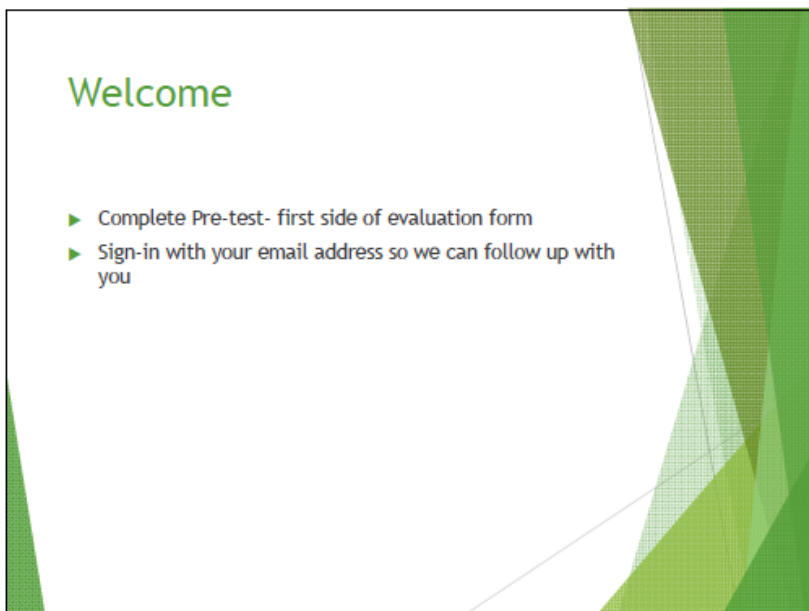
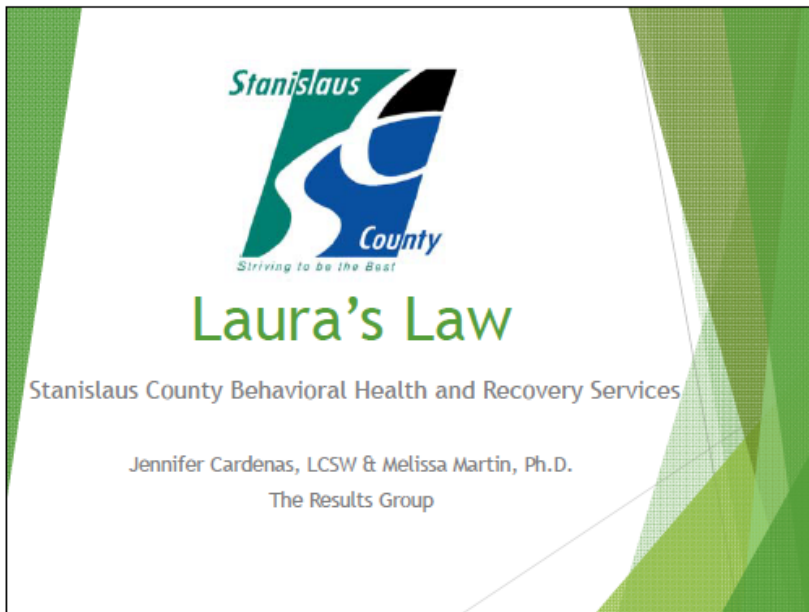
- (1) The number of persons served by the program and, of those, the number who are able to maintain housing and the number who maintain contact with the treatment system.
- (2) The number of persons in the program with contacts with local law enforcement, and the extent to which local and state incarceration of persons in the program has been reduced or avoided.
- (3) The number of persons in the program participating in employment services programs, including competitive employment.
- (4) The days of hospitalization of persons in the program that have been reduced or avoided.
- (5) Adherence to prescribed treatment by persons in the program.
- (6) Other indicators of successful engagement, if any, by persons in the program.
- (7) Victimization of persons in the program.
- (8) Violent behavior of persons in the program.
- (9) Substance abuse by persons in the program.

- (10) Type, intensity, and frequency of treatment of persons in the program.
- (11) Extent to which enforcement mechanisms are used by the program, when applicable.
- (12) Social functioning of persons in the program.
- (13) Skills in independent living of persons in the program.
- (14) Satisfaction with program services both by those receiving them, and by their families, when relevant.

SEC. 2. Section 5349.5 of the Welfare and Institutions Code is amended to read:

5349.5. This article shall remain in effect only until January 1, 2022, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2022, deletes or extends that date.

APPENDIX C – COMMUNITY FORUM EDUCATIONAL MATERIALS



Forum Agenda

- ▶ Sign-in and welcome
- ▶ PowerPoint presentation and clarifications
- ▶ Break
- ▶ Discussion group facilitation
- ▶ Break
- ▶ Report back to larger group, summarizing key themes from each group
- ▶ Next steps and wrap-up

What is Laura's Law?

- ▶ Assisted Outpatient Treatment (AOT) authorized by Assembly Bill 1421
 - ▶ https://leginfo.ca.gov/faces/billNavClient.xhtml?bill_id=200120020AB1421
- ▶ Extended to 2022 via Assembly Bill 59
 - ▶ https://leginfo.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB59
- ▶ Assisted Outpatient Treatment (AOT) is Court ordered Community Based Care that is:
 - ▶ A mobile, multidisciplinary, highly trained mental health team
 - ▶ Staff to client ratio of 1:10
 - ▶ Client directed
 - ▶ Use recovery principles
 - ▶ Assignment of a Personal Services Coordinator
- ▶ Does not mandate that the county add services
- ▶ Requires that the county does not eliminate services in order to fund AOT

What is AOT?

- ▶ Services can include:
 - ▶ Outreach to consumers and family
 - ▶ Mental health services
 - ▶ Linkage, coordination and access to:
 - ▶ Medications
 - ▶ Psychiatric services
 - ▶ Psychological services
 - ▶ Supportive housing or other housing assistance
 - ▶ Substance Abuse services
 - ▶ Vocational rehabilitation
 - ▶ Veterans' services
- ▶ Services DO NOT include:
 - ▶ "Forced" or Involuntary medication
 - ▶ Guaranteed housing
 - ▶ Guaranteed job/work/vocational training

Laura's Law eligibility

- ▶ 18 years or older with mental illness
- ▶ Unlikely to survive in community without supervision
- ▶ History of lack of treatment compliance, evidenced by one of the following:
 - ▶ Two hospitalizations or incarcerations due to mental illness in the last 36 months
 - ▶ One or more acts of serious & violent behavior, threats or attempts to harm self or others in the last 48 months
- ▶ Offered opportunity to participate in high intensity treatment but continues to fail to engage
- ▶ Condition is deteriorating
- ▶ AOT would be least restrictive treatment setting needed
- ▶ AOT would prevent deterioration/relapse
- ▶ Consumer would benefit from AOT

Court Order Process

- ▶ Civil Court Petitions must be submitted to the court by the Behavioral Health Director
 - ▶ Director can delegate this responsibility to another individual within the department
- ▶ Individuals with a relationship to the consumer can request that the Director seek petition.
 - ▶ Anyone who shares a residence
 - ▶ Immediate relatives
 - ▶ Director of any residence, public or private agency, treatment facility or charitable organization
 - ▶ Hospital Director where a consumer is hospitalized
 - ▶ Consumer's licensed mental health providers
 - ▶ Parole officer, probation officer or peace officer supervising consumer

Court Order Process

- ▶ Based on referral and other information, the Director must make a determination about eligibility and the need for a petition
 - ▶ A licensed mental health professional must
 - ▶ make appropriate attempts to elicit the consumer's cooperation in services no more than 10 days prior to filing the petition
 - ▶ be willing to testify at the petition hearing
- ▶ Consumer maintains legal rights and has access to legal counsel throughout process
- ▶ Court can issue order for AOT for up to 6 months
 - ▶ Can be extended for additional 6 months if consumer still qualifies
- ▶ Director must provide affidavit to court every 60 days affirming that the consumer still qualifies for AOT
- ▶ Consumers can petition the court to remove the order at any time

Non-compliance with court order

- ▶ Failure to comply with court order alone is not grounds for 5150 hold, hospitalization or contempt of court citation.
 - ▶ Can't be hospitalized simply due to non-compliance with court order
 - ▶ Can't be jailed for non-compliance with court order
 - ▶ Can't be mandated to receive other services (medications, housing, vocational support, etc.)
 - ▶ Can't be found in contempt of court

Stanislaus Data

- ▶ Based on data pulled from our County administrative records, we can report the following:
 - ▶ Between 12/31/13 and 12/31/16, there were 2,913 unduplicated individuals who who were hospitalized and/or incarcerated 2 or more times
 - ▶ Of those, 550 (23%) engaged in more than 2 services for over 3 months
 - ▶ 1,813 received fewer than 2 services
- ▶ However, we do NOT know how many of these individuals would assess mild/moderate post-hospitalization and/or not meet other criteria.
- ▶ We also do not know how many patients were diagnosed as primarily Substance Use Disorder who engaged in those services.

Clarifications

Discussion Groups

Future Feedback Opportunities

- ▶ Complete your post-test
- ▶ Survey to gather additional feedback
 - ▶ Link: <https://www.surveymonkey.com/r/LauraLaw>
- ▶ Contact BHRS - Debra Buckles
 - ▶ DBuckles@stanbhhs.org
- ▶ Board of Supervisors meetings
- ▶ NAMI meetings
- ▶ MHSa report - public comment
 - ▶ www.stanislausmhsa.com

APPENDIX D – ADULT SYSTEM OF CARE - LEVEL OF CARE MATRIX

Level	LOCUS Level of Care/Disposition	BHRS Program/Subunit	
Basic	Prevention & Health Maintenance	6401	Josie's Drop-In Center
		-	Peer Wellness
		-	PCP
		-	PEI Programs
		-	Community Resources/CBO's
I	Recovery Maintenance & Health Management	7201	WRC (only for step-down; not as an initial referral)
		-	Managed Care – Mild/Moderate
II	Low Intensity - Community Based Services	6803	TRS - Wellness
		4402	MRS - Wellness
		3004	IFT - Wellness
		3008	MH Court - Wellness
		3015	CC - Wellness
		6607	Wellness TRAC
		4611	HRHSA – Wellness
III	High Intensity - Community Based Services	6402	Josie's Place Service
		6802	TRS – Intensive
		4401	MRS – Intensive
		4605	SATT – Intensive
		4610	HRHSA – Intensive
		3003	IFT – Intensive
		3007	MH Court – Intensive
		3012	CC – Intensive
		6605	Fast TRAC
		6606	Telecare Modesto
IV	Medically Monitored Non-Residential Services	6614	Telecare MRS TRAC
		6619	Telecare TRS TRAC
		4405	MRS – Full Service-
		6806	TRS – Full Service-
		4609	HRHSA – ACT
		6602	Westside SHOP
		6603	Partnership TRAC
		6604	Josie's TRAC
		3002	IFT – ACT
		3006	MH Court – ACT
		3011	CC – ACT
		7007	ISA – Intensive
		3122	COD FSP – MH ACT

Assisted Outpatient Treatment
Summary & Recommendations



V	Medically Monitored	7002	ISA – ACT**
VI	Medically Managed Residential	7002	ISA – ACT**

APPENDIX E – REFERENCES

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