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

For the Reporting Period
July 1, 2018 – June 30, 2019

Department of Health Care Services
Community Services Division

May 2021
Completed by DHCS, February 2021

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Executive Summary

Assembly Bill (AB) 1421 (Thomson, Chapter 1017, Statutes of 2002) established the Assisted Outpatient Treatment Demonstration Project Act of 2002 in Welfare and Institutions (W&I) Code Sections 5345 – 5349.5, known as Laura's Law. Laura's Law requires the Department of Health Care Services (DHCS) to establish criteria and collect data outcomes from counties that choose to implement the Assisted Outpatient Treatment (AOT) program and produce an annual report on the program's effectiveness, which is due to the Governor and Legislature annually by May 1. Additionally, DHCS is required to evaluate the effectiveness of the programs' strategies to reduce the clients' risk for homelessness, hospitalizations, and involvement with local law enforcement.

This report serves as the May 1, 2020 annual report and provides outcomes for the July 1, 2018- June 30, 2019 State Fiscal Year (SFY), intended to be released in 2021.

July 1, 2018- June 30, 2019 SFY Key Highlights and Developments

DHCS has standardized the report period for this annual report to align with the SFY. Previous reports included data from January 1, 2018 through June 30, 2019. Beginning with this report, the annual DHCS report will include data from July 1, 2018 to June 30, 2019. Because the reporting period covered by this reports overlaps with data provided in the 2020 reports, there may be some data from the previous report included in this report. However, DHCS has enhanced and standardized the data to more clearly present outcomes. Therefore the presentation of data in this report may not completely align with the prior report.

This report reflects aggregate outcomes[1] for 218 individuals from 12 counties that reported court-involved[2] client data to DHCS for the July 1, 2018 - June 30, 2019 SFY.

The following reflects key highlights for this reporting period:

- Homelessness decreased by 35 percent;
- Hospitalization decreased by 39 percent;
- Contact with law enforcement decreased by 45 percent;
- 29 percent of individuals were able to secure employment or participated in employment and/or educational services;
- Victimization was decreased by 71 percent;
- Violent behavior decreased by 47 percent;
- Clients presenting with a co-occurring mental health and substance use disorder decreased substance use by 8 percent;

[1] Aggregate outcomes includes available data for each element reported by counties.
[2] "Court-involved" refers to the individuals that received services through a court petition. Petitioned individuals may waive their right to an AOT hearing that would result in a court order and receive services through a court settlement. "Court-involved" individuals or participants are used interchangeably; which will be dependent on the best flow in the context of this report.

- Most counties reported improvements in clients' social functioning and independent living skills; and,
- Client and family satisfaction surveys indicated satisfaction with AOT services.

There are four important developments for this reporting period:

1. DHCS standardized the reporting period to align with the SFY, defined elements outlined in statute, and issued a survey tool to collect county data.
2. This report includes statewide programmatic data that highlights the strategies employed;
3. 25 percent of total referred individuals[3] receiving services required court involvement to participate in AOT services, while 75 percent entered into treatment voluntarily; and,
4. Aggregate outcomes indicated a positive impact on the three outcome elements mandated by the statute governing AOT – homelessness, hospitalizations, and incarcerations.

The AOT program showed high voluntary participation – 75 percent of total individuals referred for an assessment who were located for services participated voluntarily. Data showed the program led to excellent outcomes, helping clients avoid or reduce hospitalization, homelessness, and incarceration.

Background

AB 1421 (Thomson, Chapter 1017, Statutes of 2002) established the Assisted Outpatient Treatment (AOT) Demonstration Project Act of 2002, known as Laura's Law. AOT provides for court-ordered community treatment for individuals with a history of hospitalization and contact with law enforcement. Laura's Law is named after a woman who was one of three people killed in Nevada County by an individual with mental illness, who was not following his prescribed mental health treatment. The legislation established an option for counties to utilize courts, probation, and mental health systems to address the needs of individuals unable to participate in community mental health treatment programs without supervision (see Appendix B for patient criteria and referral process). In 2008, the first AOT program was implemented in Nevada County. In 2012, program oversight was transferred from the former Department of Mental Health to DHCS and incorporated into DHCS' county mental health performance contracts[4] with the enactment of SB 1009 (Committee on Budget and Fiscal Review, Chapter 34, Statutes of 2012). AB 1569 (Allen, Chapter 441, Statutes of 2012) extended the sunset date for the AOT statute from January 1, 2013, to January 1, 2017.

The statute requires counties to provide AOT programs and does not appropriate any

[3] "Total referred individuals" refers to all referrals made across all 20 AOT implemented counties.
[4] DHCS county mental health performance contracts became effective July 2013.

additional funding to counties for this purpose. Nevada County operated the only AOT program until the passage of SB 585 (Steinberg, Chapter 288, Statutes of 2013), which authorized counties to utilize specified funds for Laura's Law services, as described in W&I Code Sections 5347 and 5348. Since the enactment of this legislation, an increasing number of counties have implemented AOT. The sunset date was again extended until January 1, 2022 with the enactment of AB 59 (Waldron, Chapter 251, Statutes of 2016) which also added the Governor as a direct recipient of this report.

AB 1976 (Eggman, Chapter 140, Statues of 2020) requires all California counties to offer AOT. Counties may offer AOT services either independently or choose to partner with neighboring counties. Counties are permitted to opt out from participation through the passage of a resolution adopted by the Board of Supervisors identifying the reasons for opting out. AB 1976 additionally repealed the sunset date of Laura's Law, extending the program indefinitely. Further, AB 1976 added a superior court judge as an eligible petitioner for AOT services to be filed for a person who appears before that judge. AB 1976 also removes the governor as a recipient of this report. AB 1976 will go into effect July 1, 2021. See Appendix A for more information on the development of AOT in California.

Introduction

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

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

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

- Adherence to prescribed medication;
- Participation in employment and/or education services;
- Victimization;
- Incidents of violent behavior;
- Substance use;
- Type, intensity, and frequency of treatment;
- Other indicators of successful engagement;
- Required enforcement mechanisms;
- Improved level of social functioning;
- Improved independent living skills; and,
- Satisfaction with program services.

Participating County Implementation and Reporting Status

As Shown in Table 1, all 20 counties that have Board of Supervisors approval to operate an AOT program submitted the DHCS issued AOT Survey Tool. Eight programs did not serve court-ordered individuals or are in the early stages of implementation; however, information was provided on their programs' progress.

Table 1. Participating County Implementation and July 1, 2018- June 30, 2019 SFY Reporting Status[5]

County	Board of Supervisor Approval	Submitted a Report to DHCS	Served Court-Involved Individuals
Alameda	X	X	X
Contra Costa	X	X	X
El Dorado	X	X	
Kern	X	X	
Los Angeles	X	X	X
Marin	X	X	
Mendocino	X	X	X
Nevada	X	X	X
Orange	X	X	X
Placer	X	X	X
San Diego	X	X	X
San Francisco	X	X	X
San Luis Obispo	X	X	
San Mateo	X	X	X
Santa Barbara	X	X	X
Shasta	X	X	
Solano	X	X	
Stanislaus	X	X	
Ventura	X	X	X
Yolo	X	X	

Data Collection and Report Methodology

Most counties have implemented their AOT programs as part of their Mental Health Mental Health Services Act (MHSA) Full Service Partnership (FSP) programs. W&I Code Section 5348(d) sets forth the reporting requirements for both the counties and

[5] Marin and Stanislaus County previously submitted July 1, 2018 - June 30, 2019 SFY data to DHCS, however neither county served court-involved individuals, therefore data was excluded from the previous AOT report. Alameda, Contra Costa, Los Angeles, San Diego, and San Francisco County previously submitted data outcomes for the 2018 Calendar year. El Dorado, Nevada, Placer, San Louis Obispo, and Yolo County previously submitted data outcomes for the May 1, 2018 through April 30, 2019 “Laura’s Law” year. Kern County previously submitted data outcomes from June 1, 2018 to May 31, 2019. Overlapped data has been included in this report; however state and federal health privacy guidelines does not allow counties or DHCS to identify individuals included in this report from the previous AOT report. Solano County received Board of Supervisors’ approval in January 2019, however DHCS was notified of the implemented program after the data submission deadline and was not included in the previous AOT report.

the state and lists the required data elements that, if available, must be included. As a result, counties obtain data for AOT clients from some or all of the following sources:[6]

- Client intake information;
- MHSA FSP Outcome Evaluation forms;
  - Partnership Assessment Form – the FSP baseline intake assessment;
  - Key Event Tracking (KET) – tracks changes in key life domains such as employment, education, and living situation;
  - Quarterly Assessment – tracks the overall status of an individual every three months. The Quarterly Assessment captures data in different domains than the KETs, such as financial support, health status, and substance use;
- "Milestones of Recovery Scale" (MORS); [7] and
- Mental Health Statistics Improvement Program Consumer Surveys – measures components that are important to consumers of publicly funded mental health services in the areas of access, quality, appropriateness, outcomes, overall satisfaction, and participation in treatment planning.

Historically, DHCS accepted data with varying reporting periods for the annual report. The reporting periods would range from calendar year, SFY (July 1 to June 30) and Laura's Law calendar year (May 1 to April 30). DHCS additionally accepted data submission in any form, including, but not limited to, email, comprehensive report, or memorandum on county letterhead. The lack of standardization has been consistently noted in past AOT reports. DHCS convened an internal workgroup over a six month period to develop the AOT Survey for data collection, define the elements outlined in statute utilizing internal data systems and federal definitions, and standardize the reporting period. All counties reported data outcomes for the July 1, 2018 - June 30, 2019 SFY using the new AOT Data Dictionary and survey tool.

Due to the small and distinct AOT population reported, clients may be identifiable. DHCS is committed to complying with federal and state laws pertaining to health information privacy and security.[8] In order to protect clients' health information and

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[6] Counties utilize additional tools including, but not limited to, pre-established assessments, surveys, and internal data sources (e.g. billing, staff reports, etc.). Data collected in these sources do not fulfill data requirements for DHCS; additionally, the same data elements are not consistent across counties.

[7] This scale was developed from funding by a Substance Abuse and Mental Health Services Administration grant and designed by the California Association of Social Rehabilitation Agencies and Mental Health America Los Angeles researchers Dave Pilon, Ph.D., and Mark Ragins, M.D., to more closely align evaluations of client progress with the recovery model. Data collected from the MORS is used with other instruments in the assessment of individuals functioning level in the Social Functioning and Independent Living Skills sections. Engagement was determined using a combination of MORS score improvement, contact with treatment team tolerance and social activity.

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

privacy rights, some numbers for each of the specified outcomes cannot be publicly reported. In order for DHCS to satisfy its AOT program evaluation reporting requirement, as well as protect individuals' health information, DHCS adopted standards[9] and procedures to appropriately and accurately aggregate data, as necessary. DHCS aggregates' are dependent upon total participants experiencing each data element. Overall totals vary.

Findings for the July 1, 2018 – July 30, 2019 Reporting Period

Statewide Findings

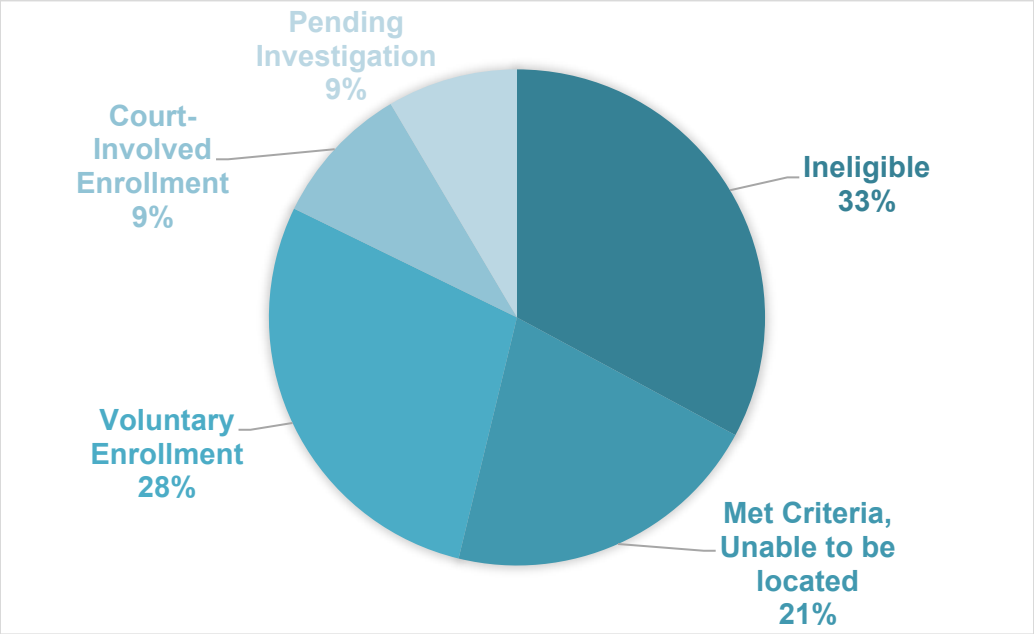
2,352 individuals were referred to AOT during this reporting period across all 20 AOT implemented counties. As shown in Figure 1, most counties reported that many referred individuals were deemed ineligible or no longer met AOT criteria after initial contact with outreach teams. Ineligible clients were given the opportunity to access less intensive behavioral health treatment services. Overall, 773 individuals were found to be ineligible. Furthermore, of the referred individuals who met AOT criteria, 492 were unable to be located for petitioning.[10] 669 participants responded to the initial invitation to voluntary services, and did not require a court petition or process; counties attribute this to successful initial outreach and engagement. 200 referrals were open and pending investigation at the end of the reporting period. The remaining 218 individuals entered AOT as a result of court orders or settlements.

Sections 1798.3, et. seq.

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

[10] Counties attribute loss of contact with participants due to individuals leaving a county once they are notified of investigation. Counties additionally report that some individuals are eventually located and re-engaged for services. These individuals may or may not be included in this report.

Figure 1. Overview of Statewide Referral, Enrollment, and Ineligibility for July 1, 2018-June 30, 19 SFY



AOT Across California

The “County Highlights” section, which was included in the previous AOT legislative reports, provides insight on the impact of AOT within each county’s respective community. DHCS expanded the programmatic data requested from all implemented counties to evaluate the effectiveness of the strategies employed by each program operated, as outlined in WIC 5348(d).

Methods of Outreach and Engagement

Counties reported an eclectic approach in working with referred individuals. Consistently, DHCS found that majority of counties took a comprehensive approach, utilizing a multitude of strategies to locate clients, triage services for each individual to determine their needs, deliver services, and make referrals as appropriate resources.

Some counties, like Ventura County, reported assessing the level of engagement and functionality of participants before, during and after AOT services. Other counties, such as Stanislaus, reported utilizing a two-stage treatment approach that first focuses on outreach and engagement and then, once a client is engaged, focuses on providing treatment and recovery services.

Counties have also adapted strategies to establish rapport and actively engage participants, while increasing medication compliance. Orange County provides an on-site pharmacy and meets with participants in the community to deliver medication in an effort to reduce barriers to medication access/support. Additionally, prescribers and case managers in Orange County actively spend over 50% of the time in the field

engaging participants in the community.

Partnerships

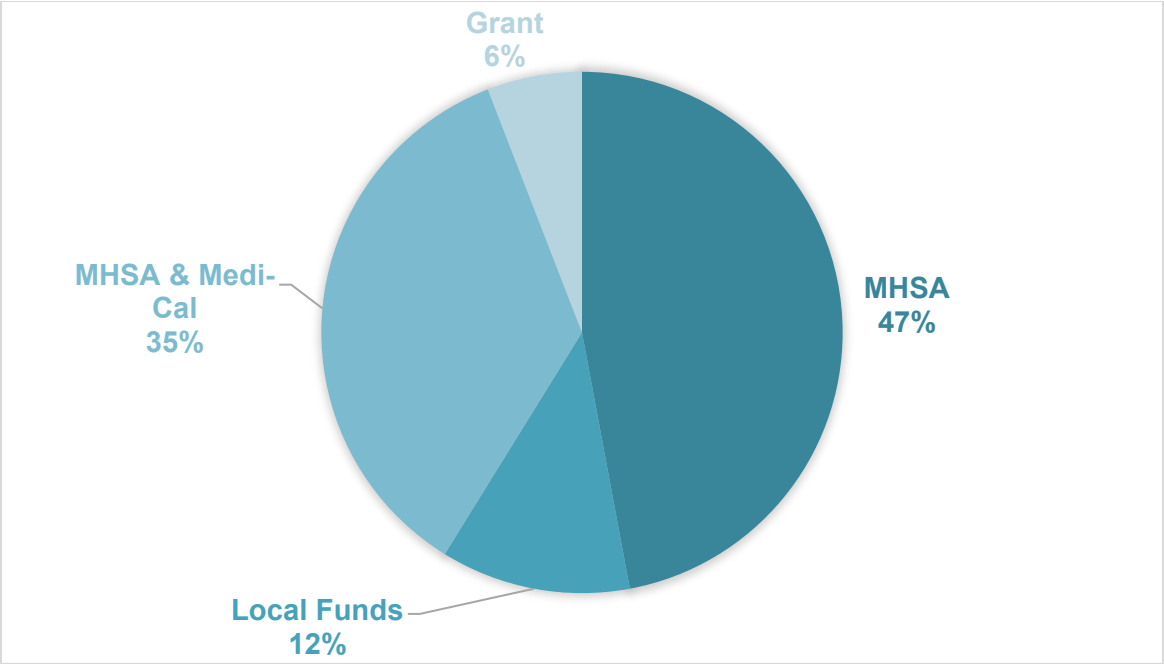
Counties developed partnerships to support AOT, including, but not limited to: housing support agencies, vocational and educational development organizations, substance use treatment resources, food and clothing aid, local police departments, clinics and hospitals. County-contracted behavioral health agencies, case managers, local universities, non-profits, inter-agency collaborative and peer groups contributed to the robust access to resources for AOT participants.

Counties created a peer support and mentoring "network" of all AOT implemented counties to ensure program success both locally and statewide. Los Angeles County conducts quarterly check-in calls with all implemented counties in California for the purpose of feedback and collaboration. Counties are provided with the opportunity to share strategies for success and request support in the development and expansion of AOT services. Nevada County, which established the first AOT program in California, has been instrumental in assisting new counties with a fundamental framework for AOT program implementation. Counties consistently report on resource and information leveraging with the experienced and established AOT programs for the purpose of navigating challenges that are unique to AOT.

Funding Sources

As shown in figure 2, most counties exclusively utilize MHSA funding to support the AOT program. Some counties report using MHSA for outreach and engagement activities, and then utilizing Medi-Cal funding once an individual receives placement at a provider. Other funding sources reported include county general funds, local behavioral health funds, and grants.

Figure 2. Overview of AOT Funding Sources for July 1, 2018- June 30, 2019 SFY



Areas of Significant Cost Reduction

Counties report considerable financial investment to address comprehensive needs of this uniquely vulnerable population when implementing the AOT program. Counties also report that investments made in the AOT program result in significant cost savings for counties, such as decreased involvement with the criminal justice system, including reduced interactions with law enforcement and reduced frequency and duration of incarceration. Another area of significant cost reduction was a decrease in the number of psychiatric and non-psychiatric hospitalizations for participants.

Court-Involved Findings

218 participants were served within the following 12 counties by court-order or court-settlement: Alameda, Contra Costa, Los Angeles, Mendocino, Nevada, Orange, Placer, San Diego, San Francisco, San Mateo, Santa Barbara, and Ventura. Statewide outcomes to evaluate program effectiveness are organized by the required data elements, with demographic information listed first.

Demographic Information

Table 2. Demographics of AOT Court-Involved Individuals for July 1, 2018- June 30, 2019 SFY[11]

DEMOGRAPHIC	TOTAL	% OF TOTAL
COURT PROCESS TYPE		
Court Order	**113**	**52%**
Court Settled	**105**	**48%**
TOTAL	**218**	**100%**
SEX/GENDER		
Female	**67**	**31%**
Male	**151**	**69%**
TOTAL	**218**	**100%**
AGE CATEGORIES		
18-25	**41**	**19%**
26-49	**135**	**62%**
50+	**42**	**19%**
TOTAL	**218**	**100%**
RACE/ETHNICITY		
Caucasian/White	**84**	**39%**
Black/African American	**27**	**12%**
Hispanic/Latino	**48**	**22%**
Asian/Pacific Islander	**30**	**14%**
Other, Multi-race, Unknown	**29**	**13%**
TOTAL	**218**	**100%**

Homelessness/Housing

Overall, homelessness was reduced by 35 percent during AOT, as compared to prior to the program. Homelessness was reduced significantly, with an increase in the number of clients maintaining housing while in the AOT program. Eight counties reported individuals successfully obtained housing through the AOT program. Alameda and Orange County noted that individuals who experienced housing instability during the program were homeless a fewer number of days than they were prior to the AOT program. Mendocino, San Francisco, and San Mateo County reported that all participants avoided homelessness while receiving AOT services.

Hospitalization

Hospitalizations were reduced by 39 percent during AOT, as compared to prior to the program. Eight counties reported a decrease in the number of days hospitalized and

[11] Percentages derived from totals are rounded to the whole numbers throughout the report.

frequency of psychiatric hospitalization. San Mateo and Santa Barbara County reported that all participants avoided hospitalizations while in the program. Ten counties reported a moderate use of crisis interventions to avoid hospitalizations.

Law Enforcement Contacts

Law enforcement contacts were reduced by 45 percent during AOT, as compared to prior to the program. Contra Costa, Nevada, and San Mateo County reported all participants avoided law enforcement contact while receiving services. Five counties that reported incarcerations of participants during AOT noted reductions in the number of days incarcerated per individual.

Treatment Participation / Engagement

Each county provides data on AOT individuals' adherence to treatment, whether or not they maintained contact with their program, and other indicators of successful engagement, as outlined in statute. The treatment participation and engagement section of this report is comprised of these three required data elements.

Data provided indicated 50 percent of participants adhered to their treatment plans and 46 percent maintained contact with their program. 43 percent of ordered participants entered treatment voluntarily when re-petitioned. Eight counties reported increased participation, program completion, SUD treatment completion, and parole/probation compliance as indicators of successful engagement.

Employment and Education

Counties reported that a majority of AOT participants have challenges in obtaining and/or maintaining employment while in treatment. Programs offer and encourage engagement in a variety of employment services including, but not limited to, vocational training, community volunteer work, and resume writing classes. AOT programs may additionally offer or refer participants to educational services (e.g. general education development assistance). Consistent with prior reports, most counties reported no employed individuals prior to AOT. Twenty-nine percent of individuals within the following 12 counties engaged in employment services and/or educational services during AOT: Alameda, Contra Costa, Los Angeles, Mendocino, Nevada, Orange, Placer, San Diego, San Francisco, San Mateo, Santa Barbara, and Ventura. Overall, four counties reported gainful employment for some of their participants.

Victimization

Historically, counties have reported individuals' reluctance to divulge their experiences of being victimized, both prior to and during AOT. Participants in the early stages of accepting treatment and recovery may refuse additional assessments and/or decline to answer victimization questions. All counties continue to note several limitations in fulfilling this required element. The available data suggests that victimization was reduced by 71 percent change during AOT, as compared to prior to the program.

Violent Behavior

Mirroring victimization, counties report similar limitations in reporting this required element. Eight counties utilize staff observations and/or statements to report violent behavior towards community providers and/or peers to supplement assessments. The provided data indicated a decrease in violent behavior by 47 percent change during AOT, as compared to prior to the program.

Substance Abuse

The majority of individuals in AOT have co-occurring diagnoses, meaning that they have both a mental health and substance use disorder and need concurrent treatment; the lack of integration of behavioral health services in most providers was reported as a barrier to access. Overall, substance abuse was slightly reduced by eight percent during AOT. Some counties reported successful SUD treatment completion among some of their participants.

Type, Intensity, and Frequency

Counties work with local stakeholders during the initial stages of implementation to determine the type, intensity, and frequency standards of AOT services. In accordance to W&I Code Section 5348, all programs provided client-centered services, which were culturally, gender, and age appropriate. Counties offer a full array of multidisciplinary services with varying frequencies and intensity. Collectively, counties averaged a minimum of four contacts per week, for approximately 60 minutes per service with court-involved participants during this reporting period.

Enforcement Mechanisms

Enforcement mechanisms to encourage and ensure treatment plan compliance may include, but are not limited to, increased number of update hearings, medication outreach and engagement to ensure compliance, and/or assessments for potential hospitalizations. Additional status hearings for the purpose of psychiatric evaluation are the most common, though counties reported high use of order renewals[12] for this reporting period. Six counties reportedly utilized enforcement mechanisms. Alameda, Orange, and Placer County avoided the use of enforcement mechanisms, while Mendocino, San Mateo, and Ventura County reported not utilizing enforcements mechanisms as a part of their AOT program.

Social Functioning

Six of nine counties that provided data,[13] reported improved social functioning of 50

[12] Counties may opt to renew petition nearing the end of the initial180 days of treatment if evaluation of participant presents cause.
[13]As outlined in WIC 5348(d), counties must provide data on required elements, if available. Social functioning data was not available for Mendocino, San Mateo, and Santa Barbara County.

percent or more of their participants. The remaining three reported low or no improved social functioning of majority of their participants. Overall, all counties reported individuals' improved ability to interact with staff, participate in extracurricular activities, and/or build peer relationships as a significant outcome.

Independent Living Skills

Eight of ten counties that provided data,[14] reported an improvement in independent living skills for 50 percent or more of their participants. Individuals demonstrated strengthened skills in stress management, food preparation, improved hygiene, and ability to utilize transportation. The remaining two counties reported similar skill levels during AOT, as compared to prior to entering the program.

Service Satisfaction

The limited data available indicated program satisfaction amongst surveyed individuals and overall treatment success. Counties issue a satisfaction survey to program participants and family members to encourage participant feedback and promote program adaptability. The majority of counties reported that they did not have access to participant counts or response rates large enough to be compliant with HIPPA laws to provide such information. Counties are encouraged to develop and issue consistent satisfaction surveys as the AOT program expands in compliance with 5348(d)(14).

Discussion

The needs of participants eligible for AOT significantly vary, thus strategies used to promote participant welfare reflected an eclectic approach. Counties engaged in comprehensive methods of outreach to locate and assess individuals, some whom were experiencing crisis. Throughout the AOT program, behavioral health staff connect participants with access to shelter, vocational and educational training, medication, counseling, and additional resources. County data indicates success in a variety of different measures, including reduced homelessness, contact with criminal justice, and hospitalizations.

Limitations

There are several noteworthy limitations of DHCS' analysis. The statewide total of court-involved clients remains small, making it difficult to determine statistically significant conclusions. Additionally, there is no comparison and/or control group[15] therefore, improvements cannot be exclusively linked to AOT program services. Some of the measures are based on self-reports and/or recollections of past events, which may or may not be accurate or reliable. Moreover, individuals enter AOT at varying times, resulting in carry-over data from prior reporting periods. DHCS now requests the number of individuals who served in a previous reporting period, however data

[14] As outlined in WIC 5348(d), counties must provide data on required elements, if available. Independent living skills data was not available for San Mateo and Santa Barbara County.
[15] Statute does not require counties or DHCS to evaluate data on voluntary participants.

outcomes for these individuals remain aggregated with the other court-involved participants. The AOT program lacks a centralized database to submit the required data, and while DHCS has attempted to leverage existing county reporting systems, those efforts have not been successful as existing databases do not encompass the required data elements.

To address limitations noted in previous reports, DHCS issued a uniformed reporting format and reporting period. However, as noted above, counties continue to utilize varying systems to collect their data. DHCS will conduct an evaluation of the survey tool and make enhancements, where appropriate, to further address limitations. Despite these limitations, DHCS' analysis suggests overall significantly improved outcomes for AOT program participants.

Conclusion

The aggregate outcomes of the 218 court-involved individuals, served across 12 counties, indicated success in reducing homelessness, hospitalizations, and incarcerations for the July 1, 2018- June 30, 2019 SFY reporting period.

Appendix A

History of Involuntary Treatment and the Development of Laura's Law in California

Among significant reforms in mental health care, the Lanterman-Petris-Short (LPS) Act (Chapter 1667, Statutes of 1967) created specific criteria by which an individual could be committed involuntarily to a locked inpatient facility for an assessment to eliminate arbitrary hospitalizations. To meet LPS criteria, individuals must be a danger to themselves or others, or gravely disabled due to a mental illness (unable to care for daily needs). Following LPS, several state hospitals closed in 1973 to reduce the numbers of individuals housed in hospitals. The intention was to have communities provide mental health treatment and support to these discharged patients. However, due to limited funding, counties were unable to secure the resources necessary to provide adequate treatment or services. As a result, many of the individuals released from the hospitals became homeless or imprisoned with very little or no mental health treatment.

In 1999, the state of New York (NY) passed Kendra's law[16], after Kendra Webdale was pushed in front of a subway train. A man with a long history of severe mental instability and multiple short stints of hospitalizations was responsible for her death. The law authorized court-ordered AOT for individuals with mental illness and a history of hospitalizations or violence. Additionally, this required participation in appropriate community-based services to meet their needs. Kendra's Law defines the target population to be served as, "…mentally ill people who are capable of living in the community without the help of family, friends and mental health professionals, but who, without routine care and treatment, may relapse and become violent or suicidal, or require hospitalization." NY requires the program to be implemented in all counties and gives priority services to court ordered individuals. Patterned after Kendra's Law, California passed Laura's Law, AB 1421(Thomson, Chapter 1017, Statutes of 2002)

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

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

Appendix B

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

- The person is 18 years of age or older.
- The person is suffering from a mental illness.
- There has been a clinical determination that the person is unlikely to survive safely in the community without supervision.
- The person has a history of lack of compliance with treatment for his or her mental illness, as demonstrated by at least one of the following:
    - At least two hospitalizations within the last 36 months, including mental health services in a forensic environment.
    - One or more acts of serious and violent behavior toward 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.
- 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 W&I Code Section 5348, and the person continues to fail to engage in treatment.
- The person's condition is substantially deteriorating.
- Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure the person's recovery and stability.
- 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 W&I Code Section 5150.
- It is likely that the person will benefit from assisted outpatient treatment.

A civil process for designated individuals, as defined in W&I Code Section 5346(b), may refer someone to the county mental health department for an AOT petition investigation. In order for an individual to be referred to the court process, the above criteria must be met, voluntary services offered, and options for a court settlement process rather than a hearing that would result in a court order.