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# **Nevada County's Assisted Outpatient Treatment Program: A Model for Other California Counties to Adopt?**

By

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## **INTRODUCTION**

In May 2008, Nevada County became the first county in California to fully implement an Assisted Outpatient Treatment (AOT) program under the guidelines established by Assembly Bill 1421 (Keller, 2011).<sup>1</sup> *The Assisted Outpatient Treatment Demonstration Project Act of 2002*, more commonly known as “Laura’s Law”, established guidelines for the court ordering of treatment for persons incapacitated by a mental disorder (California Department of Mental Health [CA DMH], 2003).

Passed in September 2002, the bill was highly controversial leading up to its passage and remains a very divisive issue today (Fagan, 2010). This paper will focus on the provisions of the law, its advantages, disadvantages, and potential for strengthening mental health service delivery in California. It will also examine the actions taken by Nevada County in their successful implementation of the law which can serve as a role model for other counties seeking options for assisting untreated, mentally ill individuals in their communities.

## **THE PROBLEM**

Launched in the 1950s, the goal behind deinstitutionalization<sup>2</sup> was to transfer care for mentally ill individuals away from the state hospital system to less restrictive, community-based treatment programs nationwide (Herbert, Downs, & Young, 2003). According to Navasky and Connor (2005), in 1955 there were 558,239 severely mentally ill patients living in the nation’s public psychiatric hospitals. In California, its 14 state hospitals housed a population of over

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<sup>1</sup> Los Angeles County implemented a small Laura’s Law pilot program in March 2003. The program was conducted in conjunction with the Los Angeles County Mental Health Court, Department 95. Individuals exiting the criminal justice system with relatively minor offenses who met AB1421 eligibility criteria were offered enrollment in an existing intensive treatment program (Southard, 2003).

<sup>2</sup> Deinstitutionalization is the name given to the policy of moving severely mentally ill people out of large state institutions and then closing part or all of those institutions (Navasky & Connor, 2005). Deinstitutionalization consists of three component processes: the release of persons residing in psychiatric hospitals to alternative facilities in the community, the diversion of potential new admissions to alternative facilities, and the development of special services for the care of a non-institutionalized mentally ill person (Lamb & Bachrach, 2001).

36,300 by the end of 1957. Closing state hospitals, it was thought, would not only save money, but provide better treatment options for those individuals in need of services. With the introduction of powerful drugs such as Thorazine, it was assumed that most mental illnesses could be treated with psychoactive drugs in a community setting. With community services available, people would be encouraged to voluntarily seek treatment earlier, before a crisis occurred, thereby helping to achieve a fuller and more rapid recovery<sup>3</sup> from their illnesses (Gabrielson, 2010). The closings were also in response to the deplorable conditions many patients experienced in the large state hospitals (Lamb and Bachrach, 2001; Lanterman-Petris-Short Reform Task Force, 1999).

Unfortunately, the transition from the state hospital system to community care did not take place as envisioned. As Fagan (2010) points out, the money saved from closing state hospitals never actually made it back into the community services. As a consequence, individuals released from the hospitals ended up in the community without the necessary medical care. This consequently led to an increase in homelessness for these former patients. Herbert et al. (2003) acknowledge the large populations of mentally ill individuals living on the streets of urban cities across the nation as a result of this policy. According to the National Alliance to End Homelessness, in California, more than one-third of the homeless population is believed to have a mental illness (Fagan, 2010).

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<sup>3</sup> For a lifelong mental illness, **recovery** refers to a reformulation of one's self-image and an eventual adaptation to the disease; recovery is one of the goals of psychiatric rehabilitation (Pratt, Gill, Barrett, & Roberts, 1999, p. 91). The National Consensus Statement on Mental Health Recovery states: *Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.* The 10 Fundamental Components of Recovery include: Self-Determination, Individualized or Person-Centered, Empowerment, Holistic, Non-Linear, Strengths-Based, Peer Support, Respect, Responsibility and Hope (Substance Abuse and Mental Health Services Administration [SAMHSA], 2006).

Complicating the issue of mental illness among homeless individuals is the fact that many people with psychiatric issues are unwilling or unable to engage in the treatment that is available to them. One estimate says that about half of the people with schizophrenia and bipolar disorder may not seek needed treatment because of a condition called *Anosognosia*.<sup>4</sup> Despite evidence to the contrary, people with this condition do not believe they are ill (Amador, 2001). In the case of paranoid schizophrenia, where the patient believes others are conspiring to harm or control their actions, the combination of Anosognosia and paranoia can provoke a violent action (Thompson, 2008). Stories of violent offenses by people with a history of mental illness are becoming more common. Forcing people into treatment, however, is easier said than done.

The current law governing forced treatment or involuntary commitment, called the *Lanterman-Petris-Short Act* (LPS), provides only for inpatient commitment and stipulates that individuals can only be involuntarily hospitalized if they pose an *immediate* danger to themselves or others or are judged to be “gravely disabled,” a legal term meaning they do not have the ability to care for themselves. The law gives physicians a 72-hour hold period to evaluate them in a locked facility and begin treatment.<sup>5</sup> Once stabilized, and no longer meeting the original criteria for their commitment, these individuals are then released. This, unfortunately, results in a revolving door of recovery and relapse as no continued care in the community is provided (National Alliance on Mental Illness [NAMI], n.d.).

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<sup>4</sup> Anosognosia (pronounced “uh-no-sog-no-zha”) (Thompson, 2008) means “unawareness of illness” and is a syndrome commonly seen in people with serious mental illness and some neurological disorders. A 1986 study by William H. Wilson, M.D., and colleagues found that 89 percent of patients with schizophrenia denied having an illness. Amador and colleagues found in a later study that nearly 60 percent of a sample of 221 patients with schizophrenia did not believe they were ill (Amador, 2001).

<sup>5</sup> Beginning in the California Welfare & Institutions Code, Section 5000, the LPS Act covers a wide range of topics including voluntary and involuntary treatment, patient rights, confidentiality and conservatorship. The rules that govern involuntary treatment are found in Section 5150 (Griffin, 2010; Lanterman-Petris-Short Reform Task Force, 1999, p.18).

Efforts to reform this commitment law have been underway for many years. Opponents of LPS have noted that, as written, the word “danger” is open to vast interpretation by law enforcement officers or health professionals who have the power to commit people with a mental illness. As such, some people are committed only after they have attempted harm to themselves or others (Bender, 2002). This, unfortunately, has often led to tragic results.

Ironically, the law passed to protect individuals who are mentally ill from long, needless hospitalizations is now denying them treatment, leaving them destitute on the streets or jailed for behavior caused by their disease (Cummings, Quanbeck, & Rouse, 2010). In fact, according to the U.S. Department of Justice, in mid-2008 there were over 2.3 million prisoners in local jails, state and federal prisons in the United States. Of this total, best studies have suggested that approximately 10 percent of prisoners have severe psychiatric disorders. Thus, at any given time, roughly 231,000 individuals with a mental illness are incarcerated in the nation’s jails and prisons (Treatment Advocacy Center [TAC], 2009a, p.1). A solution to this problem is available, though.

## **LAURA’S LAW**

The law derives its name from Laura Wilcox, a 19-year-old college student working in a Nevada County mental health clinic when she was gunned down by Scott H. Thorpe, a mentally ill 41-year-old man with a history of resisting treatment (Gordon, 2010; Seligman, 2004). As a result of this tragedy, lawmakers were finally able to pass legislation long proposed by Assemblywoman Helen Thomson (D-Davis) that would require those in need of mental health services to receive treatment (“Carry out ‘Laura’s Law’”, 2006; Fagan, 2010). Under the new law, a long list of criteria must first be met before a person is considered eligible for assisted outpatient treatment. Applebaum (2003) reports that, among the criteria, the mentally ill person

must be at least 18-years-old; be in a state or condition where their safety in the community is in jeopardy without supervision; have a history of disengagement or noncompliance resulting in hospitalization or incarceration within the past 36 months; have had one act or threat of violence towards themselves or others within the last 48 months; require outpatient assistance to prevent the relapse or further deterioration resulting in serious harm to themselves or others; or be in grave disability.

In addition, the person must first be offered the opportunity to voluntarily participate in comprehensive treatment service and refuse such service before they are considered eligible for the treatment. The person in question must already be in a state of mental deterioration. Finally, assisted outpatient treatment must be the “least restrictive placement necessary to ensure the person’s recovery and stability” (Applebaum, 2003, p.27).

*A Guide to Laura’s Law* by the California Treatment Advocacy Coalition & The Treatment Advocacy Center (2009) explains the process for initiating treatment under Laura’s Law. For example, if a person is believed to be in need of assisted outpatient treatment, a number of individuals may request that the county mental health director file a petition with the superior court in the county where the person in need of assistance is present to initiate an investigation. Those individuals who can make the request include:

- Any adult with whom the person resides
- An adult parent, spouse, sibling, or child of the person (older than 18 years of age)
- A hospital director if the person is an inpatient
- Mental health director where person is receiving services
- A treating or supervising licensed mental health treatment provider
- A parole or probation officer

Upon receiving the request, the county mental health director conducts an investigation. If a determination is made that all of the eligibility criteria for an AOT petition have been met by clear and convincing evidence, only then will the director file a petition with the court (p.4).

The petition must state: 1) the person is present or believed to be present within the county where the petition itself is filed; 2) all of the criteria necessary for placement in AOT; and 3) the facts supporting the belief that the person meets all of the criteria. The petition must also be accompanied by an affidavit of a licensed mental health treatment provider stating:

- The person has been examined no more than 10 days prior to submission of the petition
- Assisted outpatient treatment is recommended
- They are willing to testify at a court hearing, or
- Appropriate attempts were made no more than 10 days prior to the filing of the petition to examine the person but the person in question refused
- They believe person meets criteria for assisted outpatient treatment
- They are willing to examine and testify at court hearing (p.4-5)

A copy of the petition and notice of court hearings must be personally served on the person who is the subject of the petition. A notice must also be provided to the county office of patient rights and the current health care provider appointed for the person. The person who is the subject of the petition has the right to legal counsel at all stages of the AOT court proceeding, either court appointed or if able to afford it, personal legal representation. In addition, the person subject to petition has the right to the following:

- Adequate notice of the hearings
- Have a notice of hearings sent to parties designated by the person
- Receive a copy of the court-ordered evaluation



- Present evidence, call witnesses and cross-examine adverse witnesses
- Be informed of his/her right to judicial review by habeas corpus
- Not be involuntarily committed or held in contempt of court solely for failure to comply with a treatment order
- Be present at the hearing, unless he/she waives this right
- Appeal decisions and be informed of his/her right to appeal
- Receive the least restrictive treatment deemed appropriate and feasible

After a petition is filed, but before conclusion of the hearing on it, the person who is subject of the petition may choose to waive his right to a hearing and enter into a settlement agreement. The agreement must be in writing and agreed upon by all parties and the court. In the agreement, the individual in question agrees to receive treatment for a period not to exceed 180 days (initial court orders after a hearing are usually for a period of up to six months, with an option of renewal if the situation requires additional treatment). The treatment agreement has the same force and effect as a court order for treatment, including noncompliance. The agreement, however, is conditioned on the licensed mental health provider agreeing that the person can survive safely in the community (p.5).

The court shall specify the treatment services that the person is to receive. It may not require any treatment that is not included in the proposed treatment plan submitted by the examining licensed mental health provider. In consultation with the county mental health director, the court must find that:

- Ordered services are available from the county or a provider approved by the county
- Ordered services have been offered on a voluntary basis to the person in subject but have been refused or failed to engage in treatment

- All elements of the petition have been met; and
- Treatment plan incorporated in the order will be delivered to the county director of mental health or the appropriate designee (p.7)

If a person fails to comply with a court mandated order, a licensed mental health treatment provider may request that the individual be taken to a hospital to be held for up to 72 hours to determine if he or she meets the criteria for inpatient hospitalization (Welfare and Institutions Code 5150). Such a request can only be made, however, upon determining that:

- The person has failed or refused to comply with the court-mandated treatment
- Efforts were made to achieve compliance, and
- The person may need involuntary admission to a hospital for evaluation

Involuntary retention beyond the 72 hours must be pursuant to the state code for inpatient hospitalization. If the individual is found not to meet the standard for involuntary hospitalization during the evaluation period, and does not agree to stay in the hospital voluntarily, they must be released. *Failure to comply with an order of assisted outpatient treatment alone is not sufficient grounds for involuntary commitment. In addition, non-compliance will not result in a finding of contempt of court* (p.8) (California Treatment Advocacy Coalition & The Treatment Advocacy Center, 2009, p.4-8)

According to Bender (2002), those who qualify for the court-ordered outpatient treatment – most likely a very small group of individuals – will then be offered intensive, community-based, multi-disciplinary treatment that includes medication management, psychotherapy, substance abuse counseling, as well as housing and employment support services. The treatment, and ultimate goal of Laura’s Law, is to provide a “bridge to recovery” for adults who are “most overcome by symptoms of mental illness,” and who, as a result of their inability to

maintain their own treatment regimen, are functionally rendered a danger to themselves and/or others, or gravely disabled (despite not meeting current LPS criteria for involuntary evaluation and treatment (California Mental Health Directors Association [CMHDA], 2011). Doing so, it is believed, will not only assist the individual in his mental health recovery, but ultimately result in lower hospitalization, incarceration and incidents of dangerous behavior (Herbert et al, 2003).

California's outpatient commitment law is modeled very closely on a statute enacted by the state of New York (Applebaum, 2003). Kendra's Law, as it is known in New York, put a legal framework in place for court-ordered outpatient treatment after the tragic death of Kendra Webdale, a young woman pushed in front of a subway train by a mentally ill individual (New York State Office of Mental Health [NY OMH], 2005). Since its passage in November 1999, Kendra's Law has reported impressive results in service delivery. A report issued by NY OMH (2005), *Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment*, cited five years of program data that revealed very encouraging results. The results included the following:

- 74% fewer people experiencing homelessness
- 77% fewer people experiencing psychiatric hospitalization
- 83% fewer people experiencing arrest
- 87% fewer people being incarcerated
- 55% fewer attempting suicide or self-harm

Proponents of Laura's Law believe results like these can be achieved across California if, and when, the law is fully adopted. See Appendix A for a hypothetical application of Laura's Law.

## **CHALLENGES TO THE LAW**

Herbert et al. (2003) note that the law, as written, has a number of shortcomings that inhibit its wider implementation in California. When passed, counties were not mandated to adopt the new law; rather, the decision to establish an assisted outpatient treatment program was left up to each county. In addition, a number of complex (and costly) program requirements were enumerated that had to be established by the county prior to its implementation. Direct funding for the law's implementation was not provided; thus, each county would be left to fund and develop its own programs. Faced with these requirements and already dealing with fiscal shortcomings, counties so far have declined to adopt the new law ("Carry out 'Laura's Law'", 2006).

The CMHDA (2011) also points out that the law contains no provisions for forced treatment, including medication. Thus, the program can only depend on the "black robe effect" – symbolic power of the court and the seriousness of the need to comply with its order for treatment. In addition, although the new law includes a number of strict legal requirements that must be met before a person can be considered eligible for AOT services, civil rights and mental health consumer groups have long resisted the law as an attack on civil rights and the further stigmatization of individuals with a mental illness (Seligman, 2004). Some worry that such a program may not support recovery, but rather, create an environment that may drive individuals away from treatment (CMHDA, 2011).

In a posting on their website, the California Network of Mental Health Clients (2001) strongly opposes involuntary outpatient commitment laws for being extreme measures that deny the rights of people with a mental illness. They also believe that mandating treatment is coercive, counterproductive and ineffective at gaining treatment compliance. Similarly, the

United States Psychiatric Rehabilitation Association also issued a position paper opposing involuntary outpatient commitment. They believe, like the California Network of Mental Health Clients, that involuntary outpatient commitment is a discriminatory practice that violates the civil rights of people with psychiatric disabilities, of people of color, and that the practice of assisted outpatient commitment represents a failure of the public mental health system (United States Psychiatric Rehabilitation Association [USPRA], 2007).

Yet, despite fiscal and logistical obstacles, as well as resistance from some members of the mental health community on philosophical grounds, Nevada County has been able to implement Laura's Law by utilizing available funding resources, the expertise of local mental health providers and strong working relationships with community stakeholders. The positive results reported thus far – client recovery, decreased hospitalization costs and reduced incarcerations - have garnered the program a *2010 Challenge Award* by the California State Association of Counties for innovation and creativity (California State Association of Counties [CSAC], 2010). The county was also honored with a *2011 Achievement Award* by the National Association of Counties for its continuing success with the program (National Association of Counties [NACo], 2011). Nevada County has proven that Laura's Law can be successfully implemented in California.

#### **LITERATURE REVIEW:**

In order to understand the need for assisted outpatient treatment laws like Laura's Law, it is first necessary to understand the genesis of the current mental health crisis. Researching the seeds for this current conundrum involved reviewing reports on deinstitutionalization, the Lanterman-Petris-Short Act, mental health funding, homelessness figures, violence and incarceration rates, as well as hospitalization procedures. It also involved reviewing information

on New York's Kendra's Law, material from the Treatment Advocacy Center's website as well as academic studies reviewing assisted outpatient commitment laws. Several articles, both for and against Laura's Law, were published in local newspapers and served as a source of information as did documents from mental health associations. Finally, material garnered from officials in Nevada County to explain how they were able to enact this highly controversial law was analyzed. The following section highlights the material used in this report.

In an article in the *Journal of Rehabilitation*, Accordino, Porter, and Morse (2001) provide a historical overview of the deinstitutionalization movement that envisioned a major transformation in the way mental health treatment was being administered in the nation. Lamb and Bachrach (2001) also provide insight into deinstitutionalization in their article, *Some Perspectives on Deinstitutionalization*. The Frontline Series, *Deinstitutionalization: A Psychiatric "Titanic"* (Navasky & O'Connor, 2005) talks about the goals behind deinstitutionalization, primarily the move away from the large, overcrowded state hospitals famously depicted in the movie *One Flew Over the Cuckoo's Nest* (Zaentz & Douglas, 1975) to community mental health clinics where "the objective was to provide patients with the greatest degree of freedom, self-determination, autonomy, dignity, and integrity of body, mind, and spirit for the individual while he or she participates in treatment or receives services" as further defined in President Jimmy Carter's Commission on Mental Health (Navasky & O'Connor, 2005).

Accordino et al. (2001) writes how this laudable goal also failed due to assumptions and misunderstandings: that people released into the community had places to go, families to care for them, and a home setting that would contribute to their recovery. Negative community attitudes towards deinstitutionalization were also clearly not understood. The consequences of these

errors contributed to the growth in homelessness, incarcerations and violent incidents involving people with mental illnesses.

A report titled *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States* (Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010) spells out the sobering conclusion that America's jails and prisons have become our new mental hospitals. Using 2004 – 2005 data, the report found that in the United States there are more than three times more seriously mentally ill persons in jails and prisons than hospitals. A National Public Radio (NPR) broadcast underscored this conclusion in their Morning Edition episode, "Inside The Nation's Largest Mental Institution" where they describe conditions inside the "Twin Towers," a wing of the county jail in downtown Los Angeles which has been labeled as being the largest mental institution in the country (Bergman, 2008).

In his *New York Times* article, Harcourt (2007) describes another ominous trend by pointing out that women represented 48 percent of patients in state mental hospitals in 1937. By contrast, current prison admissions related to mental illness have consistently been 95 percent male. The number of minority members being admitted has also increased substantially.

Another report titled *The Shortage of Public Housing Beds for Mentally Ill Persons* (Torrey, Entsminger, Geller, Stanley, & Jaffe, 2008) emphasized how the depletion of psychiatric beds has led to many of the dire social issues mentioned above. For example, a consensus of experts polled for the report suggested that 50 public psychiatric beds per 100,000 population is the minimum number necessary to provided adequate care. Based on this number, 42 of the 50 states had less than half the minimum number of psychiatric beds necessary, with only one state, Mississippi, achieving this goal. This shortage, states Torrey et al. (2008), has led to hospital emergency rooms being overrun with mentally ill patients waiting for a psychiatric

bed. In California, 25 of the 58 counties have no acute care adult in-patient psychiatric beds at all, according to the California Hospital Association.<sup>6</sup> The Association estimates the number of acute psychiatric hospital beds declined by nearly 800 beds between the years 2005 and 2007 alone (Jacobs, 2010).

*Violent behavior: One of the consequences of failing to treat individuals with severe psychiatric disorders* by the Treatment Advocacy Center (2009b) detailed violent behavior as one consequence of failing to treat individuals with severe psychiatric disorders. One study cited in the paper covered four states – New Hampshire, Connecticut, Maryland and North Carolina - and involved 802 adults with severe mental illness (SMI). They found that those who had been violent were more likely to have been homeless, to be substance abusers, and to be living in a violent environment. Those who had been violent were also 1.7 times more likely to have been noncompliant with medications. They concluded that “risk of violence among persons with SMI is a significant problem” and “is substantially higher than estimates of the violence rate for the general population” (p. 5).

This risk of violence, however, is not an automatic determinant for inpatient hospitalization – to the consternation of many. The Lanterman-Petris-Short Reform Task Force (1999) issued a lengthy report describing how the application of inpatient hospitalizations has been limited since the passage of the Lanterman-Petris-Short Act. The group provided an overview of the history of mental health programs in California, the formation of the LPS law, its legal stipulations and subsequent limitations when it comes to providing psychiatric treatment to individuals in a state of crisis. It also details how due process has become imbalanced because of the law’s stringent behavioral criteria, pitting the state’s interest in public safety against that of

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<sup>6</sup> Based on 2009 data. Information does not include state hospital beds or privately funded institutions for mental disease (IMD) (C. Jacobs, personal communication, June 27, 2011.)



protecting individual civil rights against abuse. In this report, the task force presents a number of recommendations for reforming the current law, including the implementation of community assisted treatment programs that would provide continuity of care after hospitalization. This recommendation resembles the type of outpatient program provided under Laura's Law (Lanterman-Petris-Short Reform Task Force, 1999).

The legality of commitment laws is a topic of frequent debate and has a direct impact on Laura's Law. Many believe postponing an individual's civil rights under the process of hospitalization, no matter how ill or incapacitated they may be, is an abuse that should not be permitted by the courts. The outpatient commitment process has also generated concerns about civil rights. Certainly, both the California Network of Mental Health Clients (2001) and the United States Psychiatric Rehabilitation Association (2007) have voiced opposition to the law. However, Geller and Stanley (2005) provide a solid defense of the constitutionality of such laws and point out that, because the adoption of imminent danger as the sole standard for involuntary placement in psychiatric treatment has left hundreds of thousands incapacitated when treatment was readily available, many states have established different criteria without requiring immediate dangerousness as the sole basis. With greater frequency there is recognition that a more flexible interpretation of dangerousness, and the legitimacy of a state acting in the *parens patriae* ("parent of the country") role to help individuals who have been rendered incapable of rational decision making or self-preservation by the effects of mental illness, is a persuasive basis for commitment laws (p.130). At the time of the report, the authors cited no ruling from the Supreme Court or other federal court against the new *parens patriae*-based inpatient commitment criteria (p.131) but did point out that such standards were upheld in state courts in Washington (1989), Wisconsin (2002) and New York (2004). More importantly, the authors

state that there has never been a successful challenge to an outpatient commitment law or its standard, despite such laws being in place in over forty states (Geller & Stanley, 2005, p. 130-131). This would seem to suggest that any challenge to Laura's Law, California's own outpatient commitment statute, on the grounds of its constitutionality would prove unsuccessful.

Monahan (2008) touched upon the legality and morality debate involving mandated outpatient treatment in his article involving the application of leverage to achieve adherence to treatment. He suggested that, instead of viewing the treatment option as a form of coercion, it should be reframed in terms of a contract. For example, he points out that making acceptance of mental health treatment in the community a condition of sentencing a defendant to probation rather than jail has long been considered accepted judicial practice. In addition, he notes the practice of appointing a representative payee (in cases when warranted) for the distribution of federal disability benefits as well as offering discounted housing options in the community with treatment engagement being an unwritten, but understood criteria (Monahan, 2008).

The article addresses the variety of types of leverage legally employed which do not create the level of resistance from the media, mental health providers, advocates and consumers to treatment laws. The article also refutes the argument regarding coercion that continues to prevent the wider acceptance of Laura's Law.

Of course, the potential for coercion of mentally ill individuals is just one of the arguments made against implementing Laura's Law in California. Funding plays a much larger role in the county's decision to participate in the statute or not. As mentioned earlier in the paper, state funding was not provided to counties to assist them in meeting the service stipulations provided for under the law. Due to chronic budget shortfalls, many counties have opted not to adopt the law. Supporters of Laura's Law, however, point to funding from the

Mental Health Service Act (MHSA)<sup>7</sup> as the solution to the money problem ("Care, not excuses," 2008).

To gain a greater understanding of how mental health care in California was subsidized in the past, information was gathered from the report, *Funding Public Mental Health in California* (Gabrielson, 2010), that is found on the shared website of the University of California Los Angeles (UCLA) and Los Angeles County Department of Mental Health. It touched upon the state hospital system, the Short-Doyle Act, deinstitutionalization, Medi-Cal and the fallout from Proposition 13. Another document found on the website, *The Mental Health Services Act: An Important Step Towards Transformation* (Padwa, 2010) explained in detail how the measure originated and the type of mental health services counties provide as a result of the funding. To a lesser extent the report, *Major Milestones: 43 Years of Care and Treatment of the Mentally Ill*, was reviewed for background information (Legislative Analyst's Office, 2000).

Efforts to reform LPS and enact legislation that would allow for treatment of individuals in psychiatric distress began many years before Laura's Law was finally passed. Assemblywoman Helen Thomson (D-Davis) was among a group of advocates leading the reform effort (Bender, 2002). Though the need for changes to the law was overwhelming, the political will in Sacramento was absent. It was the death of Laura Wilcox that provided the catalyst that ultimately resulted in the passage of Laura's Law.

Laura's Law, California Welfare and Institution Code (WIC), Chapter 2, Article 9, Section 5345-5349.5, placed California among the 44 other states with similar laws that seek to

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<sup>7</sup> Placed on the ballot by California voters and passed in November 2004, Proposition 63 (known as The Mental Health Services Act or MHSA) places a one percent tax on individuals with a personal annual income of over one million dollars. The revenue generated from the tax goes directly towards expanding and improving the California mental health system. Funding is used to pay for a variety of prevention, early intervention and service needs as well as the training and infrastructure necessary to support the system. Under the law, funds may only be used to genuinely expand voluntary services for severely mentally ill persons (Scherer, 2007, p.66-67; California Department of Mental Health, 2011).

decrease the number and duration of hospitalization, homelessness, arrests and incarcerations, victimization of mentally ill individuals, violent episodes and other consequences deriving from non-treatment (TAC, n.d.). The website, Justia.com, lists the California statute in greater detail (Justia.com, n.d.). A letter sent by the California Department of Mental Health in 2003 to local mental health directors, program chiefs, administrators, health board members and county personnel describing aspects of the new law and procedures for its implementation was also reviewed (CA DMH, 2003, p. 1). An advocacy website - *Kathi's Mental Health Review* – was used for legislative background information (Stringer, 2002).

A tremendous source for information, not only on Laura's Law, but also on the need for assisted outpatient laws, was found on the Treatment Advocacy Center's website. A functional outline of the legislation as well as a report titled *A Guide to Laura's Law* was available to answer many of the questions for those unfamiliar with the law (California Treatment Advocacy Coalition & The Treatment Advocacy Center, 2009). Fact sheet material was also available that highlighted the benefits and advantages of implementing Laura's Law (TAC, n.d.).

Two newsletters published last year by NAMI-Marin County provide an excellent argument for implementing Laura's Law in the county. The February newsletter reviews the criteria by which a person can be assigned treatment under the law and provides a breakdown of the monetary costs involved in providing mental health care to inmates in the Marin County Jail system ("It's Time to Implement," 2010, p. 3-5). The March newsletter explains how the law would work, using a hypothetical scenario. It also responds to myths pertaining to the law ("Laura's Law - How it Works," 2010, p. 4-5).

*Assisted Outpatient Treatment Comes to California - or Does it?* (Herbert, Downs and Young, 2003) provides both an overview of the new law, as well its limitations. For example, it

points out that the new law does not mandate forced medication of individuals nor does it, like many assisted outpatient treatment laws, compel an individual to comply with treatment. It also does not threaten involuntary hospitalization as a result of noncompliance. Rather, the article points out that court orders deriving from an AOT law seem to provide mental health providers the added support they need for greater outreach to recalcitrant individuals in the community. In addition, the AOT court order can successfully coax long overdue compliance through the intercession of a judge as a neutral authority figure, positing that “[I]ike most Americans, most persons with mental disorders are law-abiding” (251).

While the article mentions many positive aspects of Laura’s Law, it does warn that, because of the way the law was written and the lack of compulsory mandates, it may end up being more a statement of good intentions than positive law – a “compromise” necessary to win support of those “in the legislature [who], siding with some patients’ rights activists, had blocked its passage until this year” (252) (Herbert et al., 2003, p. 251-252).

Applebaum (2003) also summarizes elements of the new law in his writing, *Ambivalence Codified: California’s New Outpatient Commitment Statute*. But, unlike the article above, he criticizes the California Legislature for their instinctive desire to offend neither side of the debate, thus sacrificing the opportunity to enact effective legislation. He also states that the law was more of an attempt to placate a public upset over a very real problem – violence by individuals with a mental disorder – following the death of Laura Wilcox. Finally, he concludes that had lawmakers truly wished to find a solution for helping those individuals living under bridges and incapable of seeking services on their own, they would have designed a statute with less restrictive eligibility criteria (Applebaum, 2003, p. 27-28).

Seligman (2004) writes on the lack of progress in implementing Laura's Law. She details the history of the law and the debate that prevents its wider usage. For example, recognizing San Francisco's decision to opt out of the law, Seligman points to the fiscal objections from county mental health officials as well as the emotional and political sensitivities that exist among supporters and opponents. Alluding to how the city has not effectively dealt with providing mental health solutions to its citizens, Seligman describes San Francisco as a city of extremes: one with a reputation for compassion but also the city with the state's highest rate of locking people up for short-term psychiatric evaluations.

Much of the support for the wider implementation of Laura's Law in California is derived from the positive reports coming out of New York involving the reduction of homelessness, incarceration and recovery rates for mental health recipients receiving treatment under Kendra's Law. Enacted a few years before the California law, Kendra's Law established an assisted outpatient treatment program to address many of the same issues envisioned under Laura's Law. A report issued by the New York Office of Mental Health (2005) detailed the program's implementation, eligibility criteria, AOT recipient demographics, short and long term findings, as well as feedback from program participants. Some of the positive results reported included 87 percent reduction in incarceration; 83 percent reduction in arrests; 77 percent reduction in hospitalization; and 74 percent reduction in homelessness (p.18, table 10). These reductions in significant events attract the attention of Laura's Law supporters who believe the law could provide the same results if properly implemented.

An independent evaluation of the program by Swartz, Steadman and Monahan (2009) focused on several key areas including regional variations in implementation, service engagement, participant outcomes, program perceptions by recipients and the impact of AOT on

New York's public mental health system. The results of the evaluation were overwhelmingly positive.

This literature review has provided an overview of historic legislation affecting the mental health field, negative impacts on society from hospital-based mental health care service reductions, and the efforts undertaken to pass reform legislation that resulted in the enactment of Laura's Law. Additional materials focused on the law's requirements, its shortcomings, and issues regarding funding, as well as funding for mental health, overall. Finally, the ongoing debate between supporters and opponents over the law's constitutionality, information regarding similar assisted outpatient treatment laws in other states, as well as articles reflecting on its limited implementation was included.

A search of Nevada County's website for published documents was conducted to get a better understanding of how the county was able to implement Laura's Law. Information collected included a resolution to adopt Laura's Law (Nevada County Board of Supervisors [Nevada County BOS], 2004), a report to the California Department of Mental Health detailing their MHSa three-year program and expenditure plan, which included the hiring of part-time personnel for Laura's Law implementation (Nevada County Behavioral Health Department [Nevada County BHD], 2007), a resolution from the board of supervisors certifying no loss of services as a result of implementing Laura's Law (Nevada County BOS, 2008a) and a resolution recommending the authorization to implement Laura's Law (Nevada County BOS, 2008b).

In addition, material provided by Michael Heggarty, the Director of Nevada County's Behavioral Health Department, including a program outcomes report (Heggarty, 2011) as well as speaker notes for a public forum on Laura's Law (M. Heggarty, personal communication, April 18, 2011) were also used. Carol Stanchfield, Program Director at Turning Point

Providence Center where the AOT services are provided, emailed information regarding their Assertive Community Treatment (ACT) program, outcome assessment procedures and the process for coordinating program implementation with community stakeholders (C. Stanchfield, personal communication, April 26, 2011). Outcome assessment procedures, as dictated by the CA DMH in a PowerPoint presentation, were also downloaded for review (CA DMH, n.d., p.9-15).

An article announcing Nevada County's implementation of Laura's Law and its relationship with Turning Point Treatment Center for providing client services (Moller, 2008) as well as another reviewing the history of Laura's Law and the progress made in helping mentally incapacitated individuals since the law was enacted in Nevada County was analyzed (Keller, 2011). Meeting minutes taken from a public forum on Laura's Law (San Diego Behavioral Health Services, 2010) as well as a articles on recent tragedies that that spurred the call for Laura's Law to be implemented in Orange (Wood, 2011) and Mendocino County (Fagan & King, 2011) were reviewed. Finally, information on Santa Barbara County's review of Laura's Law in 2003 (Broderick, 2003) and their current pilot program (Alcohol, Drug & Mental Health Services, 2011) was used for this report. In addition, information on Los Angeles County's latest AB 1421-inspired pilot program (Southard, 2011) was reviewed.

This diverse collection of information on Laura's Law paints a picture of a law that is underutilized due to civil rights concerns, funding issues and overly strict legislative criteria, but which, if implemented, offers the small group of individuals it was intended to reach an opportunity to achieve long-term mental health recovery.



## **METHODOLOGY**

The research is based on an outcome analysis of Laura's Law as implemented in Nevada County, California. The analysis follows Sylvia and Sylvia's (2004) outcome analysis methodology. This methodology has a series of related goals that lead to program outcomes, as shown in Figure 1, which evaluate the success of the program. The evaluation model chosen, found in Sylvia and Sylvia (2004) and shown in Figure 2 is a Time Series design. This design allows for the collection and comparison of data from each program participant prior to, at the beginning of, and during program treatment. Subsequent examination of collected data will highlight positive (or negative) results from program services. This will help to determine the overall efficacy of the program for achieving treatment goals.

### **Theoretical Goals:**

The Nevada County Behavioral Health Department implemented its assisted outpatient treatment (AOT) program in an effort to provide medically necessary mental health services to individuals ordered into treatment by the courts. The theoretical goals include the following:

- T<sub>1</sub> Provide treatment to individuals incapable of seeking treatment voluntarily
- T<sub>2</sub> Assist in the long-term mental health recovery of program participants

### **Program Goals:**

The goals of Nevada County's mental health program are similar to other mental health providers: deliver client-centered, evidenced-based mental health services to individuals in order to speed their recovery towards a more productive and meaningful life. Because the individuals enrolled in the AOT program have a history of disengagement from the mental health system, resulting in periods of hospitalization, incarceration and homelessness, addressing these areas will be a key emphasis. The *Final Report on the Status of Assisted Outpatient Treatment* by the

New York State Office of Mental Health (2005) discussed goals established for their program.

Nevada County's AOT program would be similar in nature. They include:

- G<sub>1</sub> Provide access to intensive mental health services (T<sub>1</sub>)
- G<sub>2</sub> Reduce incidence of harmful behavior to themselves and others (T<sub>1</sub> – T<sub>2</sub>)
- G<sub>3</sub> Improve quality of life for program participants (T<sub>1</sub> - T<sub>2</sub>)

### **Program Functions:**

In order to provide the type of treatment necessary to achieve the goals listed above, Nevada County is relying on services provided by a mental health agency based in Sacramento. Using an Assertive Community Treatment (ACT) modality, recommended by SAMHSA for treating individuals with severe mental illnesses (M. Heggarty, personal communication, April 18, 2011), services will include the following:

- F<sub>1</sub> Case management (G<sub>1</sub> – G<sub>3</sub>)
- F<sub>2</sub> Medication management (G<sub>1</sub> – G<sub>2</sub>)
- F<sub>3</sub> Psychotherapy (G<sub>1</sub> – G<sub>2</sub>)
- F<sub>4</sub> Rehabilitation counseling (G<sub>1</sub> – G<sub>3</sub>)
- F<sub>5</sub> Substance abuse counseling (G<sub>1</sub> – G<sub>2</sub>)
- F<sub>6</sub> Employment support (G<sub>1</sub>, G<sub>3</sub>)
- F<sub>7</sub> Housing support (G<sub>1</sub>, G<sub>3</sub>)
- F<sub>8</sub> Educational support (G<sub>1</sub>, G<sub>3</sub>)

### **Proximate Indicators:**

The book, *Program Planning and Evaluation for the Public Manager* by Sylvia & Sylvia (2004) lists generic indicators as one way to gauge progress towards achieving program goals (p.124). Mental health agencies, like other public organizations, are required to keep extensive records regarding the type and recipients of services provided. As mentioned above, because many of the individuals coming into the AOT program have long histories of incarceration, hospitalization and homelessness, indicators for the program may include noting the number of incidences in those key areas that occur after enrollment in the program. Other indicators may

provide feedback that mental health progress is being made in other areas, such as housing or employment goals. As such, proximate indicators may include:

- I<sub>1</sub> Detrimental behavior/adverse events (F<sub>1</sub> – F<sub>5</sub>)
- I<sub>2</sub> Level and quality of mental health services (F<sub>1</sub> – F<sub>8</sub>)
- I<sub>3</sub> Sustained participation in program services (F<sub>1</sub> - F<sub>5</sub>)
- I<sub>4</sub> Client employment status (F<sub>1</sub>, F<sub>4</sub>, F<sub>6</sub>)
- I<sub>5</sub> Client education status (F<sub>1</sub>, F<sub>4</sub>, F<sub>8</sub>)
- I<sub>6</sub> Client housing status (F<sub>1</sub>, F<sub>4</sub>, F<sub>7</sub>)
- I<sub>7</sub> Self-care and maintenance (F<sub>1</sub> – F<sub>5</sub>)
- I<sub>8</sub> Social and community engagement (F<sub>1</sub> – F<sub>5</sub>)
- I<sub>9</sub> Staff perception of services (F<sub>1</sub> – F<sub>8</sub>)
- I<sub>10</sub> Client/family satisfaction (F<sub>1</sub> – F<sub>8</sub>)

### **Program Measures:**

In order to assess the program's impact on its participants, Nevada County employs a number of measuring tools that gather critical information on the individual at the introduction of service, when key milestones occur during participation in the program, and on a quarterly basis. Such tools include the Milestones of Recovery Scale (MORS), Partnership Assessment Form (PAF), Key Event Tracking (KET) and Quarterly Assessment Form (CA DMH, n.d.). Attitudinal indicators such as client/family satisfaction and staff perception surveys are also used (C. Stanchfield, personal communication, April 26, 2011). These tools synthesize collected data and assist program evaluators in determining whether the program is meeting its goals. Program measures include:

- M<sub>1</sub> Time series review of clinical records regarding level of functioning (I<sub>1</sub>, I<sub>3</sub> – I<sub>8</sub>)
- M<sub>2</sub> Time series review of clinical records regarding detrimental behaviors (I<sub>1</sub>)
- M<sub>3</sub> Time series review of client records regarding engagement with program services (I<sub>3</sub>)
- M<sub>4</sub> Time series review of clinical records measuring development of skills and support system (I<sub>3</sub> – I<sub>8</sub>)
- M<sub>5</sub> Review of program records measuring personal milestones (I<sub>3</sub> – I<sub>8</sub>)
- M<sub>6</sub> Client/family satisfaction survey (I<sub>10</sub>)
- M<sub>7</sub> Staff perception survey (I<sub>9</sub>)
- M<sub>8</sub> Review of program records on service delivery (I<sub>2</sub>)
- M<sub>9</sub> Review of program records on expenditures/costs (I<sub>2</sub>)

**Program Outcomes:**

An analysis of the data gathered from program measures will reveal the extent to which the program met its goals. Secondary outcomes (positive or negative) can also be determined.

The expected outcomes are as follows:

- O<sub>1</sub> Reduced incidents of harmful behavior (M<sub>2</sub>)
- O<sub>2</sub> Lower program service costs (M<sub>8</sub>)
- O<sub>3</sub> Successful delivery of intensive, client-centered mental health services (M<sub>6</sub> –M<sub>9</sub>)
- O<sub>4</sub> Progress made in long-term mental health recovery of client (M<sub>4</sub> – M<sub>6</sub>)
- O<sub>5</sub> Empowerment of program participants to achieve personal goals (M<sub>4</sub> – M<sub>6</sub>)
- O<sub>6</sub> Client/family satisfied with program services (M<sub>6</sub>)

**Figure 1: Outcome Analysis**

Theoretical Goals	Program Goals	Program Functions	Proximate Indicators	Program Measures	Program Outcomes
T <sub>1</sub> Provide Treatment	G <sub>1</sub> – Access to MH Service (T <sub>1</sub> )	F <sub>1</sub> Case Mgmt (G <sub>1</sub> – G <sub>3</sub> )	I <sub>1</sub> Harmful behavior/events (F <sub>1</sub> – F <sub>5</sub> )	M <sub>1</sub> Time series level of functioning (I <sub>1</sub> , I <sub>3</sub> – I <sub>8</sub> )	O <sub>1</sub> Reduced harmful behavior/events (M <sub>2</sub> )
	G <sub>2</sub> Reduce Harmful Behavior (T <sub>1</sub> – T <sub>2</sub> )	F <sub>2</sub> Medication Mgmt (G <sub>1</sub> – G <sub>2</sub> )	I <sub>2</sub> Quality of MH Services (F <sub>1</sub> – F <sub>8</sub> )	M <sub>2</sub> Time series harmful behavior/events (I <sub>1</sub> )	O <sub>2</sub> Lower program costs (M <sub>8</sub> )
	G <sub>3</sub> Improve Quality of Life (T <sub>1</sub> – T <sub>2</sub> )	F <sub>3</sub> Psychotherapy (G <sub>1</sub> – G <sub>2</sub> )	I <sub>3</sub> Sustained participation (F <sub>1</sub> – F <sub>5</sub> )	M <sub>3</sub> Time series service engagement (I <sub>3</sub> )	O <sub>3</sub> Delivery of MH services (M <sub>6</sub> – M <sub>9</sub> )
		F <sub>4</sub> Rehab Counseling (G <sub>1</sub> – G <sub>3</sub> )	I <sub>4</sub> Employment Status (F <sub>1</sub> , F <sub>4</sub> , F <sub>6</sub> )	M <sub>4</sub> Time series Development of support system (I <sub>3</sub> – I <sub>8</sub> )	O <sub>4</sub> Long-term client progress (M <sub>4</sub> – M <sub>6</sub> )
T <sub>2</sub> Assist in long-term recovery		F <sub>5</sub> Substance Abuse Counseling (G <sub>1</sub> – G <sub>2</sub> )	I <sub>5</sub> Educational Status (F <sub>1</sub> , F <sub>4</sub> , F <sub>8</sub> )	M <sub>5</sub> Time series personal milestones (I <sub>3</sub> – I <sub>8</sub> )	O <sub>5</sub> Empowerment personal goals (M <sub>4</sub> – M <sub>6</sub> )
		F <sub>6</sub> Employment support (G <sub>1</sub> , G <sub>3</sub> )	I <sub>6</sub> Housing Status (F <sub>1</sub> , F <sub>4</sub> , F <sub>7</sub> )	M <sub>6</sub> Survey client satisfaction (I <sub>10</sub> )	O <sub>6</sub> Client satisfied with services (M <sub>6</sub> )
		F <sub>7</sub> Housing support (G <sub>1</sub> , G <sub>3</sub> )	I <sub>7</sub> Self care (F <sub>1</sub> – F <sub>5</sub> )	M <sub>7</sub> Survey staff perception (I <sub>9</sub> )	
		F <sub>8</sub> Educational support (G <sub>1</sub> , G <sub>3</sub> )	I <sub>8</sub> Community Engagement (F <sub>1</sub> – F <sub>5</sub> )	M <sub>8</sub> Record review service delivery (I <sub>2</sub> )	
			I <sub>9</sub> Staff perception (F <sub>1</sub> – F <sub>8</sub> )	M <sub>9</sub> Record review program costs (I <sub>2</sub> )	
			I <sub>10</sub> Client satisfaction (F <sub>1</sub> – F <sub>8</sub> )		

**EVALUATION DESIGN:**

The evaluation design chosen to gauge the effectiveness of Nevada County’s current AOT program is the Time-Series design, shown in Figure 2. As mentioned in Sylvia & Sylvia’s book (2004), the greatest source of the design’s popularity is that it can be applied after a program has already begun (p.154). This would be applicable in this case as Nevada County launched its program in early 2008. In addition, because Nevada County collects various data at the beginning and throughout an individual’s enrollment in the AOT program, it should be an effective means for tracking changes in mental health status. Baseline or background information for each individual is gathered using the Partnership Assessment Form. Subsequent information on client progress is gathered using a Quarterly Assessment Form or Key Event Tracking Form. The collection of data is indicated by the letter “O”. The initiation of outpatient treatment is indicated by the letter “X”.

Utilizing this simple, but effective, evaluation format should provide information to those considering implementing their own AOT program. It will provide data demonstrating whether the application of a program based on similar goals and objectives can bring about the changes desired in those individuals ordered into treatment.

**Figure 2: Time Series Evaluation Design**

<b>Group members</b>	<b>Baseline Information</b>	<b>AOT enrollment</b>	<b>3 month evaluation</b>	<b>6 month evaluation</b>
Individuals court-ordered into treatment or voluntarily enrolled	O	X	O	O

## **FINDINGS:**

To date, Nevada County remains the first and only county in California to fully implement AB 1421, Laura's Law (NACo, 2011). To do so, they initiated a training and education outreach program for major stakeholders – county officials, hospital staff, law enforcement, consumers of mental health services and their families, as well as members of the community at large – covering the details of the law and how it would be applied (C. Stanchfield, personal communication, April 26, 2011). They also established key strategic working partnerships with a number of departments and community agencies necessary to facilitate elements of the law (M. Heggarty, personal communication, April 18, 2011). Under the guidance of the state's department of mental health, Nevada County has been able to resolve questions of program funding by utilizing a stream of revenue already approved by the voters of California.

As a result of these efforts, in the three years that Nevada County has offered its assisted outpatient treatment program, it has demonstrated impressive results, underscoring how effective the law can be in treating individuals who have previously been incarcerated, hospitalized, homeless, and who have declined mental health services in the past. The following section is an overview of the results from Nevada County's implementation of Laura's Law. Data referenced below covers the period from program launch in May 2008 through November 2010.

## **PROGRAM RESULTS:**

A total of 24 candidates were referred for assisted outpatient treatment (AOT) since May 2008. All candidates have histories of hospitalization and/or incarceration with threats of violence towards themselves or members of the community. Of the 24 candidates, 19 have met the criteria established for the AOT program under AB 1421 (Heggarty, 2011, p.1).

While the law is predicated on mandating treatment, according to Nevada County officials, the vast majority of those individuals enrolled in the program agreed to undergo treatment voluntarily, avoiding court proceedings and other more restrictive and coercive treatment models. Of the 19 individuals, only five court orders have been needed to support candidates in agreeing to undertake treatment, or in being evaluated in a hospital setting. Progress data collected on individuals in the program include ratings from the Milestones of Recovery Scale (MORS) which reflect measurements of recovery or mental health improvement. The components of MORS include Levels of Risk, Engagement, and Skills and Supports. The ratings score individuals in treatment on how they are progressing in recovery using an eight point scale ranging from number one (1) Extreme Risk to number eight (8) Advanced Recovery (Heggarty, 2011, p.4). See Appendix B for a description of the Milestones of Recovery Scale.

Pre-AOT and post-AOT MORS data was collected on only 16 of the 19 candidates. As Heggarty explained, some data on individuals could not be gathered due to incarceration outside the county, unknown whereabouts or other reasons. In addition, individuals tended to move in and out of program eligibility, so data numbers may not always add up neatly when measuring outcomes (Heggarty, 2011, p.5).

As such, of those 16 individuals with valid MORS scoring, 14 had initial MORS scores in the Struggling category, ranging from Extreme Risk to Poorly Coping. Two individuals were in the Succeeding category, ranging from Coping to Advanced Recovery. Post AOT scores, however, indicated that only eight individuals remained in the Struggling category; the other eight were in the Succeeding category (Heggarty, 2011, p.5). Program participant progress is depicted in Figure 3 below.



**Figure 3: MORS progress at pre-AOT and post-AOT intervals**

<b>Recovery Category</b>	<b>Pre-AOT</b>	<b>Post-AOT</b>	<b>Improvement</b>
Struggling	14	8	43 percent
Succeeding	2	8	300 percent

Besides the Milestones of Recovery Scale, officials also utilize the Partnership Assessment Form (PAF), Key Event Tracking (KET) and Quarterly Assessment Form gauging client progress (CA DMH, n.d.). Attitudinal indicators such as client/family satisfaction and staff perception surveys are also used (C. Stanchfield, personal communication, April 26, 2011).

As listed under the Program Outcomes section of this paper, notable indicators of program success include positive outcomes in terms of a reduction in hospitalization and incarceration rates. Nevada County has reported significant reductions in those two key areas for the 19 individuals participating in the AOT program. For example, prior to program participation, the individuals spent 514 days of hospitalization. Since enrollment in the AOT program, however, the number of hospitalization days was reduced almost 62 percent to 198 days. In addition, incarceration levels were also positively affected. Prior to program participation, the 19 individuals spent 521 days incarcerated. Since enrollment in the AOT program, that number was reduced to 17 days of incarceration, a reduction of approximately 97 percent (Heggarty, 2011, p.5). These results are depicted in Figure 4 below.

**Figure 4: Reduction in harmful events pre-AOT and post-AOT**

<b>Key Indicator</b>	<b>Pre-AOT</b>	<b>Post-AOT</b>	<b>Improvement</b>
Hospitalization	514 days	198 days	62 percent
Incarceration	521 days	17 days	97 percent

Still another indicator of program success involves the employment status of the participants. Nevada County reported that prior to enrollment, 5 of the 19 individuals were gainfully employed. Since AOT enrollment, one additional member of the group has gained employment (Heggarty, 2011, p.5-6). Also, four or five of the individuals are now serving as peer counselors to the other participants in the program (San Diego County Behavioral Health Services [SDC BHS], 2010, p. 7). Information provided by Carol Stanchfield (personal communication, September 15, 2011) regarding a reduction in homelessness by program participants indicates an approximately 62 percent reduction in the number of homeless days. Outcomes mentioned cover 12 months prior to treatment and 12 months of program enrollment.

## **COSTS**

According to Nevada County, prior to enrollment in the AOT program, the cost of the 514 days of hospitalization for the 19 participants totaled \$346,950 or \$675 per day. A reduction in hospitalization usage from 514 days to 198 days resulted in total costs of \$133,650, a savings of \$213,300. Cost savings from reduced incarcerations were also dramatic. The 521 days the 19 individuals spent incarcerated in prison resulted in total costs of \$78,150 or \$150 per day. A reduction in incarceration from 521 days to 17 days resulted in total costs of \$2,250, a savings of

\$75,600 (Heggarty, 2011, p.5). Cost savings for both hospitalization and incarceration are depicted in Figure 5 below.

**Figure 5: AOT Program Cost Savings**

<b>Indicators</b>	<b>Pre-AOT</b>	<b>Post-AOT</b>	<b>Savings</b>
Hospitalization	\$346,950	\$133,650	\$213,300
Incarceration	\$78,150	\$2,550	\$75,600

Since launching its assisted outpatient treatment (AOT) program, Nevada County has reported total program expenses of \$482,443. This figure is based on 31 months of service delivery for the 24 referred individuals, of which 19 were eligible and received AOT treatment (Heggarty, 2011, p.5). Actual annualized cost per participant was \$10,750. This figure, according to Heggarty, was calculated by multiplying the number of participants in the program by the total number of service minutes provided multiplied by the actual cost per minute for the period of time the participant received treatment. Costs include all expenses associated with service delivery per Medicaid cost reporting standards and practices. Whenever possible, Medicaid was claimed for covered mental health treatment services. There were no county general funds included or required in the funding stream (Heggarty, 2011, p.4).

**SAVINGS**

Total program cost of \$482,443 plus the actual hospital and incarceration costs for 31 months of treatment, \$136,200, totaled \$618,643. Based on utilization data from 12 months prior to the implementation of the program, the projected hospital and jail costs **without** the AOT program for the same period of time (31 months) were projected to be much higher,

\$1,122,264. As such, implementation of the program has thus far resulted in **a net savings of \$503,621** for Nevada County (Heggarty, 2011, p.5). To further illustrate the cost savings to the county with the AOT program in place, for every dollar spent on its assisted outpatient treatment program Nevada County saves \$1.81 in reduced hospitalization and incarceration costs (C. Stanchfield, personal communication, September 15, 2011).

## **FUNDING**

Nevada County has been able to utilize Mental Health Service Act funds for its assisted outpatient treatment (AOT) program. There is still some dispute surrounding the usage of MHSA funds for mental health treatment services that are considered involuntary, as Laura's Law has been labeled by its critics. In their position paper, *AB 2357- Why Oppose It*<sup>8</sup>, the California Network of Mental Health Clients (2006) points out that guidelines established by the CA DMH regarding the use of MHSA funds restrict its application to voluntary treatment services. They cite the Requirements for Community Services and Support (CSS) programs which states: Individuals accessing services funded by the Mental Health Services Act may have voluntary or involuntary legal status which shall not affect their ability to access the expanded services under this Act. *Programs funded under the Mental Health Services Act must be voluntary in nature* (CA DMH, 2005, p. 4). The fact that treatment in an AOT program can be mandated for some individuals leads critics of Laura's Law to argue against the use of such funds.

But Heggarty (personal communication, April 18, 2011), states that the county was granted approval by the CA DMH to use the voter-approved funds for its new treatment program, provided that the funding not be used towards involuntary service components. For

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<sup>8</sup> Authored by Assemblymembers Betty Karnette (D-Long Beach) and Leland Yee (D-San Francisco), AB 2357 sought to extend the sunset provision of Laura's Law for another five years, till January 1, 2013 (NAMI, 2011). The bill was signed into law in late September, 2006 (Senator Leland Yee, 2006).

example, Nevada County had to assure the CA DMH that MHSA funds would not be used to pay for police, judges or courtroom staff, only treatment services (Nevada County Behavioral Health Department, 2008).

During a forum on Laura's Law in November 2010, Heggarty explained that the Mental Health Service Act as written does not specifically distinguish between voluntary or involuntary services. Rather, the CA DMH, following their MHSA guidelines, advised the county against using the funds for involuntary services (SDC BHS, 2010, p.16). In their discussions with the CA DMH regarding Laura's Law implementation, Nevada County argued that its AOT program was indeed voluntary in nature. Though it may include court orders for some of its participants, the court mandated treatment was no different than other types of accepted court ordered treatment, such as probation, or when individuals are court wards or court dependents (Heggarty, 2011, p.6).

Furthermore, county officials pointed out that force or compulsion is never used to get individuals to participate in treatment, the service facilities themselves are unlocked and participants are free to live at home with family and engage in normal life activities such as working or attending school while receiving treatment. Ultimately, the decision to participate in the AOT program is still within the control of the individual to decide for himself (Heggarty, 2011, p.6). Thus, by utilizing funding solely for treatment services, Nevada County has made it possible for its MHSA service plan – which includes the Laura's Law component – to be approved by CA DMH on a yearly basis since its initial program launch (SDC BHS, 2010, p.16).

## **SERVICE DELIVERY**

Nevada County contracted with Turning Point Treatment Programs, a Sacramento-based non-profit, to provide treatment services to individuals taking part in the assisted outpatient treatment (AOT) program (Heggarty, 2011, p.3; Keller, 2011; Moller, 2008). Based on a 1:25,000 ratio, Nevada County expects to provide AOT services to five individuals a year (M. Heggarty, personal communication, April 18, 2011). Those services follow the evidenced-based (ACT) modality supported by SAMHSA (Heggarty, 2011, p.2; NAMI, 2007). ACT services involve intensive outpatient treatment offered 24 hours per day, 7 days per week (Assertive Community Treatment Association [ACTA], 2007; NAMI, 2007).

Services are provided by a multi-disciplinary team of professionals with a clinician to participant caseload ration of 1:10. A Personal Services Coordinator is assigned to each participant but any member of the team is capable of providing services to the participant. The team wraps diverse services around the individual and his family utilizing a “whatever it takes” attitude to assist the individual in achieving service plan goals (Heggarty, 2011, p.2). Service plans are strength-based and highly individualized, created with full participation of the individual and his support base, such as family and friends. In addition, most services are provided outside of an office environment, in an individual’s home, place of employment, school or wherever the individual chooses (ACTA, 2007; Heggarty, 2011, p.6). This treatment arrangement offers flexibility to both the individual receiving services and the provider offering the services.

The types of services provided to participants of the program include psychotherapy, psychiatric medication support, nursing, rehabilitation counseling, substance abuse counseling, employment support as well as housing support. In addition, a flexible funding account allows

for the purchase of food, clothing, shelter and other personal resources as needed to support service plan goals and objectives (Heggarty, 2011, p.2). According to a NAMI report, costs associated with ACT services are frequently estimated at \$10,000 to \$15,000 per person per year, based on a team of about 10-12 people and a 1:10 staff-to-consumer ration. Medication and housing can add additional costs (NAMI, 2007). Nevada County has put the cost of their ACT treatment at \$20,000 per person. Though admittedly an expensive treatment option, Nevada County considers the cost to be more than justified, as most of the individuals in their AOT program were previously hospitalized – some for an entire year – or locked in institutions for mental disease (IMD) where treatment is more expensive and involuntary (SDC BHS, 2010, p.7).

In addition, NAMI points out that ACT has a proven track record of helping individuals with the greatest needs – and with the most severe illness – who have not been helped by other services. Compared to traditional case management programs, high fidelity ACT programs result in fewer hospitalizations, increased housing stability, and improved quality of life for individuals experiencing serious impairment from mental illness (NAMI, 2007).

## **IMPLEMENTATION**

Prior to implementing an AOT program, the CA DMH required participating counties to fulfill a number of statutory provisions. Such provisions included the following:

- **Board of Supervisor’s Resolution** certifying no voluntary mental health program serving adults or children would be reduced as a result of implementing an AOT program<sup>9</sup>
- Assurance of Compliance letter signed by the Director stating that the county will comply with the provisions of the law as codified in WIC Sections 5345 – 5349.5

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<sup>9</sup> Listed in Welfare & Institutions Code Section 5349 (CA DMH, 2003).

- **Documentation of Mental Health Board’s review** of county’s AOT implementation plans
- **Program description** specifying the number of clients to be served, services to be delivered, means of providing services, county processes for handling AOT program request, involuntary medication policies, as well as other items
- **Program budgeting overview** detailing source of funds for the program
- **Baseline budget** showing expenditures for current voluntary and involuntary mental health services
- **Data collection and evaluation plans** detailing how the program will collect specified data and evaluate program effectiveness
- **Training and education program** describing the county’s plan to involve various stakeholders in the development of training and education program  
(CA DMH, 2003, p.2-3)

On September 28, 2004 Nevada County’s Board of Supervisors passed Resolution No. 04-462 formally declaring their intention to implement Laura’s Law in the county (Nevada County BOS, 2004). In addition, the county issued Resolution No. 08-67 on February 26, 2008 that assured the CA DMH that no voluntary services would be negatively impacted with the implementation of Laura’s Law (Nevada County BOS, 2008). The final resolution, No. 08-164, on April 22, 2008 officially requested authorization for the implementation of Laura’s Law in the county (Nevada County BOS, 2008).

Leading up to the passage of the April 2008 resolution, Nevada County had taken steps necessary for program implementation, including program design, contracting, staffing, and community training and education (C. Stanchfield, personal communication, April 26, 2011). In



addition to contracting with Turning Point Community Programs for ACT services as mentioned earlier, Nevada County worked in collaboration with several county stakeholders, including the Behavioral Health Department, Superior Court, County Counsel, Sheriff's Department, and Public Defender's office (Heggarty, 2011, p.3). In addition, Nevada County consulted with the Treatment Advocacy Center in Arlington, Virginia, the county's Adult Protective Services, the local NAMI office and SPIRIT Peer Empowerment Center in Grass Valley, California. Trainings on the new program were also provided to local hospitals, out-of-county psychiatric facilities, consumers, their families and the community at large (C. Stanchfield, personal communication, April 26, 2011).

Stanchfield (personal communication, April 26, 2011) pointed out that mental health clients and family advocacy organizations, including NAMI and the Mental Health Board, were invited by Nevada County to participate in all training programs.<sup>10</sup> Their participation strengthened the standard of care in providing services to those at risk of being treated in higher levels of restricted treatment. All trainings included a review of the process and criteria for a person referred for consideration to AOT treatment. The required forms, a review of patient rights, scenarios and sample treatment plans are also included in the trainings. See Appendix C - E for a copy of the AOT Brochure, Treatment Plan and Mental Health Provider Declaration Form.

The training and education efforts focused on three target audiences:

- **Legal Training and Education** for those in law enforcement, the court systems, community stakeholders and Behavioral Health providers

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<sup>10</sup> Listed in Welfare & Institutions Code Section 5349(1)(a) requires that counties implementing an AOT program consult with the CA DMH, client and family advocacy organizations as well as other stakeholders to develop a training and education program (CA DMH, 2003).

- **Hospital Training and Education** for those in crisis services, hospital staff, community stakeholders and Behavioral Health providers
- **Service Training and Education** for all providers, including peer support, crisis intervention, therapists, psychologists, psychiatrists and community stakeholders

(C. Stanchfield, personal communication, April 26, 2011)

Written into Nevada County's Community Services Supports (CSS) Plan was a request for a part-time clinical position to act as a liaison between the court system and the ACT program. The licensed mental health practitioner serves as a liaison to the courts, but also provides assessment and referral services as well as psychotherapy sessions to ACT team participants. The position is paid for with MHSA funds (M. Heggarty, personal communication, April 18, 2011; Nevada County BHD, 2007, para 5; SDC BHS, 2010, p. 22).

## **OVERSIGHT**

The assisted outpatient treatment (AOT) program is under the oversight of the Nevada County Behavioral Health Department's Compliance Officer. All service documentation and billing are fully in accordance with local, state and federal statutes. Service provision and medical records are consistent with Medicaid and Medicare standards. In addition, the assisted outpatient treatment program maintains high fidelity to SAMHSA guidelines for ACT service provisions (Heggarty, 2011, p.7). In accordance with Section 5346 (6)(h) of the law, at intervals of not less than 60 days during an assisted outpatient treatment order, the director of the outpatient treatment program must file an affidavit with the court affirming that the person subject to the original order continues to meet the criteria for assisted outpatient treatment (Justia.com, n.d.). In addition, Section 5348 (5)(d) states that Nevada County is required to provide specific data to the state department of mental health, which in turn submits a report to

the Legislature on or before May 1 of each year. The report is used to evaluate the effectiveness of AOT programs in operation at reducing homelessness, hospitalization and incarceration rates (CA DMH, 2003).

#### **ANALYSIS and CONCLUSION:**

In 2002, California signed legislation authorizing court-mandated mental health services for individuals in need of treatment but incapable of or opposed to receiving it. Laura's Law was supposed to fill a gap in the state commitment law that makes it difficult to force a mentally unstable person into treatment until there is an immediate threat of danger to the individual or others. Unfortunately, almost 10 years later, the law has not been adopted by county governments due to fiscal, logistical and philosophical concerns. Only Nevada County, with a population of just under 100,000, nestled in the Mother Lode country of the Sierra Nevada (Nevada County, 2011), has fully implemented the law.

Based on the outcome analysis model established for evaluating Nevada County's implementation of the Laura's Law-inspired program, results indicate that the treatment program has fulfilled its expectations. The original goals cited for the new program included the following:

- Provide access to intensive mental health service
- Reduce incidence of harmful behavior to themselves and others
- Improve quality of life for program participants

Data from a list of proximate indicators, program measures commonly used in the mental health community and a review of the outcome results expected from the new AOT program conclusively validate the clinical effectiveness of the program. Not only have program participants experienced greater mental health stability since enrollment in the program, as seen

in Figure 3 on page 31 but both hospitalizations and incarcerations (harmful events) have been dramatically reduced, as seen in Figure 4 on page 32. The employment status and level of participation for participants have increased. In terms of homelessness, the number of days participants experienced being homeless has been drastically reduced.

Nevada County has also reported considerable cost savings as a result of program implementation. Reductions in incarcerations and hospitalizations have saved the county over \$500,000 based on actual program expenses versus projected costs for those same services if the program were not in place. In addition, because the vast majority of those who meet the strict eligibility criteria voluntarily agree to participate in services, costly court procedures are avoided. This acceptance of treatment has also made it possible to achieve the positive clinical results in the short period of time that the program has been in place. This success should serve as an example to the other counties still unsure about adopting Laura's Law.

The use of Assertive Community Treatment services, an evidenced-based, intensive treatment modality, by Nevada County has undoubtedly improved clinical outcomes for program participants. Funding for such services is already available under the Mental Health Service Act. Therefore, counties that provide ACT services – as part of their full service partnership (FSP) programs<sup>11</sup> – already have the necessary tools in place to treat individuals under Laura's Law. Heggarty (personal communication, April 18, 2011) surmises that assisted outpatient treatment could be overlaid upon existing caseloads in current ACT teams with no resulting voluntary

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<sup>11</sup> **Full Service Partnership** programs provide individuals with a broad spectrum of services to aid in their movement towards recovery. This includes mental health services and supports, such as medication management, crisis intervention, case management and peer support. It also provides non-mental health services such as food, housing, respite care and treatment of co-occurring disorders, such as substance abuse. A key element of full service partnership programs that are different from the current usual care is that it provides a more intensive level of care and a broader range of services (Scheffler, Felton, Brown, Chung & Choi, 2010).

service reduction. He also pointed out that counties are, in all likelihood, already treating many of the same individuals that would be referred for services under Laura's Law.

The lack of funding for Laura's Law is frequently cited as a reason for not establishing an assisted outpatient treatment (AOT) program in their county. However, Nevada County was provided permission by the state department of mental health to use Mental Health Service Act funding for its program prior to launch. By applying funds directly towards the treatment component of their program, they have avoided being denied the use of funding for 'involuntary' treatment.

Although opponents of assisted outpatient treatment programs have launched legal challenges in the past, the court system has consistently upheld the constitutionality of such laws. For instance, Kendra's Law in New York was upheld in the case of *In re Urcuyo* (2000). The following year, the courts reached a similar conclusion in the case of *In re Martin* (2001) (Zdanowicz, 2003). Modeled closely to Kendra's Law, Nevada County has yet to face any legal challenges to its assisted outpatient treatment (AOT) program.

#### **RECOMMENDATION:**

The evidence is clear: **Laura's Law works and should be adopted statewide.** Nevada County provides a turnkey model for how it can be implemented into a county's existing mental health service infrastructure using MHSA funding. The time to do so is now. Deinstitutionalization, though well intentioned, has been a catastrophic failure. Designed to end the practice of warehousing mentally ill individuals in state hospitals, it instead released them into communities without the necessary continuity of care required to maintain mental stability. The Lanterman-Petris-Short Act champions the rights of individuals to manage their own

treatment, but does not address whether or not the individual has the capacity to do so. It also makes it extremely difficult to force incapacitated individuals back into treatment.

Both of these policies have shaped the way society has dealt with the mental health crisis over the past 40 years or so. Laura's Law, a more recent attempt at correcting flaws in the system by directing untreated individuals towards mental health services, has remained largely unused. Yet, the need for the law has not diminished, if anything, the need for wider implementation has become more evident. Incidents like those that spurred the passage of Laura's Law continue to take place in California.

In Mendocino County this past August, Aaron Bassler – a troubled 35-year-old individual with a history of schizophrenia – set off a manhunt by law enforcement officials when he ambushed Jere Melo, a Fort Bragg Councilman, and his colleague while they were out inspecting a water line suspected to be supplying a hidden marijuana field in the forest. Believed to be guarding a small opium poppy field nearby, Bassler opened fire on the men, killing Melo. Bassler was later tied to another shooting death, that of conservationist Matthew Coleman in early August (Romney, 2011). Bassler was later killed by law enforcement after a five week manhunt (Fagan & King, 2011). Bassler's father said his son long resisted any notion of his illness and deteriorated after diversion programs he was enrolled in ended. Mr. Bassler is now urging Mendocino County to adopt Laura's Law (Romney, 2011).

The call for Laura's Law implementation is also coming from members of the community in Orange County. The Board of Supervisors asked for a report on possible implementation in the county following the aftermath of the July 5th beating death of Kelly Thomas, a homeless man with severe schizophrenia, by Fullerton police (Wood, 2011b). Thomas' death set off community outrage and calls for the county to adopt Laura's Law (Gerda,

2011). A preliminary report on the feasibility of implementing Laura’s Law was recently provided to the county board of supervisors (Wood, 2011a).

Both of these incidents should have county officials throughout the state exploring the feasibility of implementing Laura’s Law in order to avoid similar tragedies from transpiring in their communities. While Laura’s Law may not represent a “silver bullet” for dealing with all that is broken in the mental health field today, it does make it possible to engage some hard-to-reach individuals in treatment. Nevada County has proven that. That being said, short of full adoption of Laura’s Law, counties may choose to explore Laura’s Law-inspired pilot programs that two counties, Los Angeles and Santa Barbara County, have implemented.

#### **SANTA BARBARA**

In September 2003, the Alcohol, Drug & Mental Health Department (ADMHS) of Santa Barbara County submitted a report to their board of supervisors recommending against the adoption of Laura’s Law. It cited a lack of funding, the complexity of the law’s mandates and the limited ability to enforce court orders as reasons for not implementing the new law. Instead, it offered a number of local alternatives as possible replacements. Such alternatives included:

- Sustaining existing 24/7 services
- Forming a committee to improve access to ACT services
- An AOT court-related program
- Closer collaboration with law enforcement agencies

(Broderick, 2003)

Neither of these options, however, satisfied the need for an effective approach to engaging untreated mentally ill individuals in county services.<sup>12</sup> As such, in May of this year, a new voluntary pilot program called Assertive Community Treatment, Outreach and Engagement (ACTOE) was launched (“Assertive Community Treatment program launched,” 2011). Under the pilot program, three existing ACT teams will reach out to 15 seriously mentally ill, high-risk individuals who are not currently engaged in services (Cooper, 2011b). People such as the person’s family, friends, social workers and anyone else can nominate the person for treatment, and if the individual qualifies, ACT members will approach that person for up to 90 days to try and convince him to seek treatment on his own (Cooper, 2011a).

The program will depend on the patients accepting help voluntarily, instead of the court-ordered treatment program as provided for under Laura’s Law. According to a Santa Barbara County Grand Jury report, “How well ACT can break the resistance to voluntary treatment, or whether or not ACT will utilize legal avenues at its disposal to compel treatment, will be major factors in determining success.” Dr. Ole Behrendtsen, states that demand for the new pilot program is very large, with roughly 186 patients in the county that could benefit from the program (Cooper, 2011a). See Appendix F for ACTOE eligibility criteria.

Santa Barbara County has chosen to utilize its existing mental health services, with an emphasis on outreach activities for dealing with a very serious dilemma in their community. Further analysis will be necessary to establish whether this approach can be as effective as fully implementing a Laura’s Law program.

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<sup>12</sup> At a monthly NAMI meeting in April of this year, the Director of Alcohol, Drug & Mental Health Services for Santa Barbara County, Ann Detrick, reaffirmed the county’s decision not to implement Laura’s Law due to fiscal concerns (Cooper, 2011a).



## **LOS ANGELES COUNTY:**

Los Angeles County has also employed a pilot program that attempts to reach the same target population as Laura's Law. In April 2010, the Los Angeles County Department of Mental Health implemented a voluntary assisted outpatient treatment pilot program administered by Countywide Resource Management (CRM) for individuals with mental illness involved in the criminal justice system, in the psychiatric units of County hospitals or in Institutions for Mental Diseases (IMDs). The County is using existing Mental Health Service Act funds to contract with Gateways Hospital and Mental Health Center (Gateways) to provide a voluntary AOT program that is available to Los Angeles County residents (Southard, 2011).

The Gateways' AOT program serves 10 individuals at any given time, with an anticipated length of stay of six months. The program provides a staff-to-client ratio of 1:10 with emergency or crisis intervention services available 24 hours a day, 7 days a week. In addition, Gateways provides wrap-around services and housing at two different adult residential facilities for participants of the program. Housing AOT participants in a residential setting with intensive supportive services promotes an ongoing engagement and participation in the AOT program (Southard, 2011). In addition to AB 1421 criteria, program eligibility criteria also include:

- Misdemeanor incompetent to stand trial defendants who have been adjudicated restored to competency by the Los Angeles County Mental Health Court and are exiting the legal system;
- Misdemeanor defendants at risk for becoming incompetent to stand trial;
- Individuals transitioning from alternative sentencing programs; and
- Individuals transitioning from County hospitals and IMDs who would be able to live safely in the community if they participated in the recommended AOT program

Based on a report submitted to the state department of mental health in January 2011, the program has had some success in helping those individuals participating in the program (Southard, 2011). But, because the report covers a short period of time (nine months) and the program is limited to such a small number of individuals, it is too early to establish its long term effectiveness in helping untreated mentally ill individuals. More research will be necessary to say definitely whether this program, perhaps in an expanded format, can serve as a credible alternative to fully implementing Laura's Law in Los Angeles County.

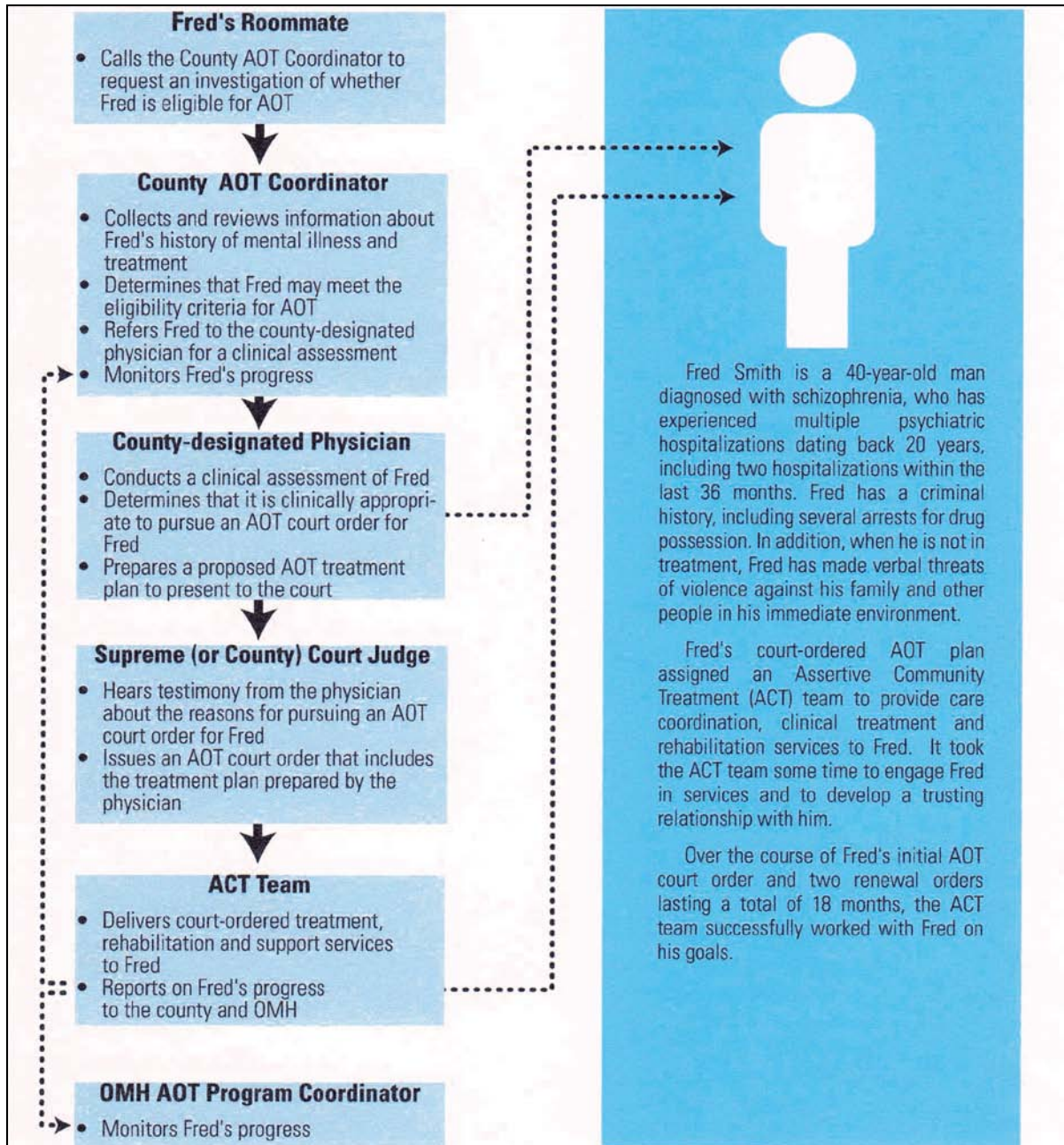
## APPENDIX A

# Laura's Law— Assisted Outpatient Treatment (AOT)

This is how it works.

Fred Smith's Experience with AOT (To prevent recognition, "Fred Smith" is a composite of several actual AOT cases with similar histories and outcomes).

(Adapted from Kendra's Law-A Final Report on the status of AOT, dated March 2005)



## APPENDIX B

### Milestones of Recovery Scale (MORS)

Dave Pilon, Ph.D. and Mark Ragins, M.D.  
(ASOC Handout 02/14/07)

Please circle the number that best describes the current (typical for the last two weeks) milestone of recovery for the member listed above. If you have not had any contact (face-to-face or phone) with the member in the last two weeks, please check here and do not attempt to rate the member. Instead, simply return the form along with your completed assessments.

1. **“Extreme risk”** – These individuals are frequently and recurrently dangerous to themselves or others for prolonged periods. They are frequently taken to hospitals and/or jails or are institutionalized in the state hospital or an IMD. They are unable to function well enough to meet their basic needs even with assistance. It is extremely unlikely that they can be served safely in the community.

2. **“High risk/not engaged”**- These individuals often are disruptive and are often taken to hospitals and/or jails. They usually have high symptom distress. They are often homeless and may be actively abusing drugs or alcohol and experiencing negative consequences from it. They may have a serious co-occurring medical condition (e.g., HIV, diabetes) or other disability which they are not actively managing. They often engage in high-risk behaviors (e.g., unsafe sex, sharing needles, wandering the streets at night, exchanging sex for drugs or money, fighting, selling drugs, stealing, etc.). They may not believe they have a mental illness and tend to refuse psychiatric medications. They experience great difficulty making their way in the world and are not self-supportive in any way. They are not participating voluntarily in ongoing mental health treatment or are very uncooperative toward mental health providers.

3. **“High risk/engaged”** – These individuals differ from group 2 only in that they are participating voluntarily and cooperating in ongoing mental health treatment. They are still experiencing high distress and disruption and are low functioning and not self-supportive in any way.

4. **“Poorly coping/not engaged”** – These individuals are not disruptive. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They may not think they have a mental illness and are unlikely to be taking psychiatric medications. They may have deficits in several activities of daily living and need a great deal of support. They are not participating voluntarily in ongoing mental health treatment and/or are very uncooperative toward mental health providers.

5. **“Poorly coping/engaged”** – These individuals differ from group 4 only in that they are voluntarily participating and cooperating in ongoing mental health treatment. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals

and/or jails. They may have moderate to high symptom distress. They are not functioning well and require a great deal of support.

6. **“Coping/rehabilitating”** – These individuals are abstinent or have minimal impairment from drugs or alcohol. They are rarely being taken to hospitals and almost never being taken to jail. They are managing their symptom distress usually, though not always, through medication. They are actively setting and pursuing some quality of life goals and have begun the process of establishing “non-disabled” roles. They often need substantial support and guidance but they aren’t necessarily compliant with mental health providers. They may be productive in some meaningful roles, but they are not necessarily working or going to school. They may be “testing the employment or education waters,” but this group also includes individuals who have “retired.” That is, currently they express little desire to take on (and may actively resist) the increased responsibilities of work or school, but they are more or less content and satisfied with their lives.

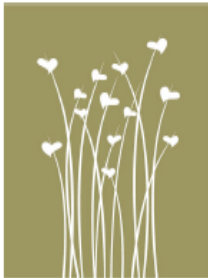
7. **“Early Recovery”** – These individuals are actively managing their mental health treatment to the extent that mental health staff rarely needs to anticipate or respond to problems with them. Like group 6, they are rarely using hospitals and are not being taken to jails. Like group 6, they are abstinent or have minimal impairment from drugs or alcohol and they are managing their symptom distress. With minimal support from staff, they are setting, pursuing and achieving many quality of life goals (e.g., work and education) and have established roles in the greater (non-disabled) community. They are actively managing any physical health disabilities or disorders they may have (e.g., HIV, diabetes). They are functioning in many life areas and are very self-supporting or productive in meaningful roles. They usually have a well-defined social support network including friends and/or family.

8. **“Advanced Recovery”** – These individuals differ from group 7 in that they are completely self-supporting. If they are receiving any public benefits, they are generally restricted to Medicaid or some other form of health benefits or health insurance because their employer does not provide health insurance. While they may still identify themselves as having a mental illness, they are no longer psychiatrically disabled. They are basically indistinguishable from their non-disabled neighbor.

## APPENDIX C

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Laura Wilcox was a 19 year old college student for whom *Laura's Law* is named. Laura was interning at the Nevada County Mental Health Clinic when she was tragically shot and killed by a man overcome by the symptoms of severe mental illness. *Laura's Law* is landmark mental health legislation offering an opportunity for individuals who meet specific criteria to receive needed mental health support through intensive mental health services, benefiting individuals and the community alike.



### Contact Information

#### Referrals

If you are among those authorized to request AOT Treatment under the provisions & know a person who may meet criteria and benefit from this valuable treatment, please contact Nevada County Behavioral Health at (530) 265-1437 and ask to speak to the Adult Services Program Manager about an AOT referral.

#### Additional information

can be obtained by contacting Turning Point Providence Center at (530) 273-5440. Providence Center is contracted with NCBH to provide AOT services. Or, check out one of the resources listed below to learn more about Laura's Law.

#### On the Web:

- ◇ [treatmentadvocacycenter.org](http://treatmentadvocacycenter.org)
- ◇ [Lauraslaw.net](http://Lauraslaw.net)
- ◇ [savelives@lauraslaw.net](mailto:savelives@lauraslaw.net)
- ◇ "Guide to Laura's Law" [State.Activity/California.htm](http://State.Activity/California.htm)

Laura's Law



Assisted  
Outpatient  
Treatment

W&I Code 5345~5349  
Court Ordered  
Mental Health  
Treatment



TURNING POINT  
COMMUNITY PROGRAMS  
a path to mental health

Providence Center

Laura's Law~ AB 1421 ~ AOT ~ W&I CODE 5345~5349  
ASSISTED OUTPATIENT TREATMENT

**THE NEVADA COUNTY ASSISTED OUTPATIENT TREATMENT PROGRAM, ALSO KNOWN AS "LAURA'S LAW" WAS IMPLEMENTED IN MAY OF 2008 OFFERING ASSISTED OUTPATIENT TREATMENT THROUGH TURNING POINT PROVIDENCE CENTER AND FUNDED THROUGH THE MENTAL HEALTH SERVICES ACT.**

**AOT PROVIDES**

COURT- ORDERED VOLUNTARY SERVICES FOR ADULTS, 18 AND OVER WITH A SERIOUS MENTAL ILLNESS WHO MEET VERY SPECIFIC CRITERIA.

**QUALIFIED INDIVIDUALS**

- ◆ LIVE IN NEVADA COUNTY AND HAVE A HISTORY OF LACK OF PARTICIPATION IN NEEDED MENTAL HEALTH TREATMENT
- ◆ THERE IS A CLINICAL DETERMINATION THAT THE PERSON IS UNLIKELY TO SURVIVE SAFELY IN THE COMMUNITY
- ◆ THE PERSON HAS BEEN OFFERED AN OPPORTUNITY TO PARTICIPATE IN TREATMENT

- ◆ THE PERSON'S MENTAL ILLNESS HAS TWICE BEEN A FACTOR LEADING TO PSYCHIATRIC HOSPITALIZATIONS OR INCARCERATIONS WITHIN 36 MONTHS OF THE PETITION, OR THE PERSON'S MENTAL ILLNESS HAS RESULTED IN ONE OR MORE SERIOUS ACTS OF VIOLENCE (OR ATTEMPTS) TOWARD SELF OR OTHERS WITHIN 48 MONTHS
- ◆ AOT IS NEEDED TO PREVENT RELAPSE OR DETERIORATION THAT WOULD LIKELY RESULT IN GRAVE DISABILITY OR SERIOUS HARM TO SELF OR OTHERS AND AOT WOULD BE THE LEAST RESTRICTIVE TREATMENT
- ◆ THE PERSON'S CONDITION IS SUBSTANTIALLY DETERIORATING AND WOULD BENEFIT FROM TREATMENT.

**WHO CAN REQUEST AOT?**

- ◆ Any person 18 and older with whom the person resides.
- ◆ The person's parent, spouse, sibling or child, who is 18 or older may request AOT treatment on behalf of their family member.
- ◆ A peace officer, parole or probation officer assigned to supervise the person may request services

- ◆ The director of a public or private agency providing mental health services to the person
- ◆ The director of a hospital where the person is being treated.
- ◆ A licensed mental health provider who is supervising or treating the person, the may request AOT

**SERVICES PROVIDE:**

- ⇒ Community-based support
- ⇒ Multidisciplinary teams including medication and specialty supports/groups
- ⇒ High staff-to-client ratio
- ⇒ Individualized service plan
- ⇒ 24/7 on-call support
- ⇒ Provisions for least restrictive housing options
- ⇒ Collaboration and linkage
- ⇒ Outreach
  
- ⇒ Services include, but are not limited to those listed above.



**APPENDIX D**

**Turning Point Providence Center  
Assisted Outpatient Treatment**

**AOT Treatment Plan**

**Candidate:**

**PSC:**

**Client ID #:**

**Treatment Goal #1:** *Client will participate in AOT mental health treatment as discussed in court. Assisted Outpatient Treatment to reduce risk factors that lead to hospitalization or incarceration.* Treatment will be provided through Turning Point Providence Center, a mental health provider contracted with Nevada County Behavioral Health.

**Objective:** 1) Avoid hospitalization and incarceration 2) Strengthen relationship with family and others. 3) Establish and maintain independent living in the community

**Treatment Goal #2:** *Client will avoid use of illegal substances to reduce risks leading to hospitalization.*

Treatment will be provided through Turning Point's Certified Alcohol and Drug Counselor and community groups (AA) weekly to support recovery.

**Objective:** 1) Reestablish healthy relationships. 2) Learn coping strategies to replace illegal drug use and identify alternate drug free social activities that promote a health lifestyle.

**Strengths:** Client is pleasant and shows the ability and desire to cooperate with others. Client wants to be well and stay out of hospitals and criminal justice facilities. Client is resourceful in meeting her needs. Client has previously engaged in recovery goals.

**Challenges:** Client has a history of inconsistent participation in mental health treatment, along with illegal substance use, factors that have led to hospitalizations in the past. Thought disturbances, hallucinations, and personal decisions ~judgment place client in unsafe circumstances, increasing client's risk of harm to self and others.

**Individual will:**

1. Meet with the Turning Point psychiatrist monthly or more often as needed and take medications as prescribe to reduce risk of severe thought and mood disturbances. This arrangement will be monitored and reevaluated in 180 days.
2. Client will meet with PSC at least one time per week and CADC specialist as scheduled
3. Accept help from the treatment team and other natural or formal supports and provide authorizations to increase network of support to enhance recovery.
4. Client will contact AOT team as needed for additional support 24/7;
5. Client will learn and utilize relaxation and other learned coping skills to manage stress.

**Treatment team will:**

1. Psychiatrist will meet with client monthly to monitor benefits and side effects of medications prescribed.
2. Treatment team will meet with client in person and by phone to support client with treatment objectives.

**Date Resolved:** 180 days from Settlement Agreement or Court Order

**SIGNATURES** (Client and Provider have agreed to this plan and to participate in the treatment process).

Client Signature: \_\_\_\_\_ Date \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date \_\_\_\_\_

Co-signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date \_\_\_\_\_



**APPENDIX E**

**DECLARATION**

I, \_\_\_\_\_, do declare: I am a qualified licensed therapist working with a candidate being considered for Laura’s Law.

I have reason to believe the Assisted Outpatient Treatment criteria are met. This individual’s condition is substantially deteriorating. She/he is in need of assisted outpatient treatment in order to prevent further deterioration that would likely result in grave disability or serious harm to herself/himself or others. I have attached the AOT checklist to this declaration and am willing to elaborate on this at the hearing. The “exam” or psycho-social assessment was offered to client on \_\_\_\_\_. Client refused the exam as well as all voluntary mental health treatment. I have written a treatment plan to be offered to the client at the time of the exam. I have reason to believe this individual will benefit from AOT as evidenced by past success when complying with treatment.

I declare under the penalty of perjury under the law of the State of California that the foregoing is true and correct.

\_\_\_\_\_  
Print: Declarant

\_\_\_\_\_  
Sign: Declarant

Date: \_\_\_\_\_

## APPENDIX F

### Assertive Community Treatment, Outreach and Engagement (ACTOE)

#### Criteria for admission to High Risk ACT Slots

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 request for admission to the ACT program.
  - 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 request for admission to the ACT program.
5. The person has been offered an opportunity to participate in a treatment plan at a lower level of care, and the person continues to fail to engage in treatment.
6. The person's condition is substantially deteriorating.
7. Participation in the ACT 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 ACT services 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 ACT services.

#### Request for evaluation by ACT program for High Risk slots

1. A request may be made only by any of the following persons to the ACT program:
  - a. Any person 18 years of age or older with whom the person who is the subject of the request 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 request.
  - 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 request in whose institution the subject of the request resides.
  - d. The director of a hospital in which the person who is the subject of the request 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 request.
  - f. A peace officer, parole officer, or probation officer assigned to supervise the person who is the subject of the request.
2. Upon receiving a request pursuant to paragraph (1), the ACT team shall conduct an investigation into the appropriateness of the filing of the request. If the ACT team determines that there is a reasonable likelihood that all the necessary elements to sustain the request are present, engagement in therapeutic process will begin.

## **Reference**

### **W&I Code 5600.3 – Subdivision B, paragraphs 2 and 3:**

- (b) (1) Adults and older adults who have a serious mental disorder.
- (2) For the purposes of this part, "serious mental disorder" means a mental disorder that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Serious mental disorders include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders. This section shall not be construed to exclude persons with a serious mental disorder and a diagnosis of substance abuse, developmental disability, or other physical or mental disorder.
- (3) Members of this target population shall meet all of the following criteria:
- (A) The person has a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a substance use disorder or developmental disorder or acquired traumatic brain injury pursuant to subdivision (a) of Section 4354 unless that person also has a serious mental disorder as defined in paragraph (2).
- (B) (i) As a result of the mental disorder, the person has substantial functional impairments or symptoms, or a psychiatric history demonstrating that without treatment, there is an imminent risk of decompensation to having substantial impairments or symptoms.
- (ii) For the purposes of this part, "functional impairment" means being substantially impaired as the result of a mental disorder in independent living, social relationships, vocational skills, or physical condition.
- (C) As a result of a mental functional impairment and circumstances, the person is likely to become so disabled as to require public assistance, services, or entitlements.

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