Assisted Outpatient Treatment Services (Laura's Law)

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SUMMARY

In 2002, the California State Assembly passed the Assisted Outpatient Treatment Demonstration Project Act (AB1421). AB1421, also known as "Laura's Law," was developed in response to the 2001 Nevada County shooting of a mental health worker by a man who was not receiving treatment. AB1421 provides court-ordered intensive outpatient services for individuals with severe mental illness who refuse voluntary treatment yet are also at risk for self-harm or grave disability. AB1421 outlines the target population and eligibility criteria per Welfare and Institutions Code (WIC) Section 5346, and the service goals and requirements of AB1421 programs. These programs, known as Assisted Outpatient Treatment (AOT), attempt to address a gap in the continuum of treatment for these individuals.

On September 2, 2014 the County of Santa Barbara Board of Supervisors directed staff to work with affected departments, external partners, and stakeholders to assess the feasibility of and potential resource needs for implementing Assisted Outpatient Treatment (AOT), otherwise known as Laura's Law in Santa Barbara County and to return within 6 months with those findings. Per the Board's direction, the review is to include the following components:

Assessment of resources, capabilities, and costs to address the criteria for AOT and related support services as required per AB1421 Laura's Law and Welfare and Institutions Code Sections 5345-5459.5 which includes:

- Community based multidisciplinary mental health teams at appropriate ratios
- Determination of approximate numbers to be series at key points thought the system
- Outreach programming
- Ability to meet all needs referred within the code
- Family and Peer Supports capabilities
- Rehabilitation and Recovery
- Integrated Psychiatric and Psychological services provided in collaboration with service planning
- Programming for adults at risk of being homeless
- Needs of the with diverse cultural backgrounds
- Provision of housing supports (immediate, transitions and permanent)
- Designation of services coordinators to facilitate aspects of the service spectrum.

BACKGROUND

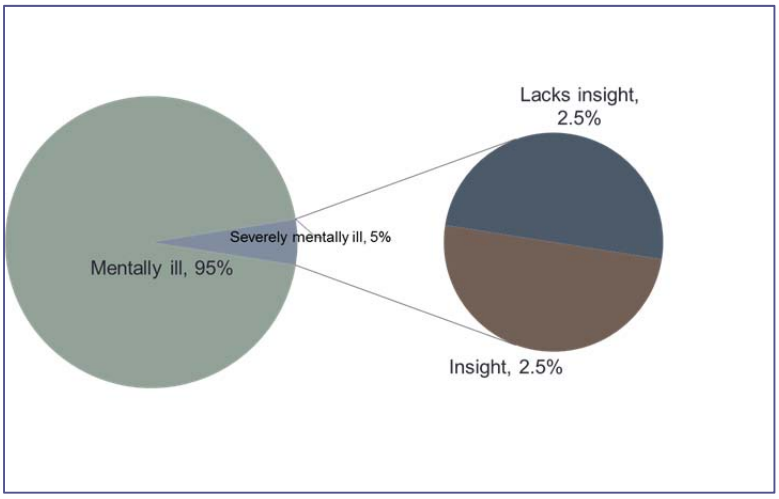
Santa Barbara County initially reviewed the feasibility of implementing AOT in September of 2003. At that juncture given the overall cost and status of services within the system, it was determined that AOT would not be pursued. However, in order to ensure that many of the services inherent in AOT were available to the community the existing Assertive Community Treatment Teams (ACT) were expanded to include enhanced outreach and engagement and 10:1 staff ratios. This enhanced service level was termed ACTOE or Assertive Community Treatment with Outreach and Engagement. Presently, 5 ACTOE slots each exist within Santa Barbara, Lompoc and Santa Barbara for a total of 15 slots Countywide. In addition, 275 regular ACT slots are in place countywide.

WHAT IS ASSISTED OUTPATIENT TREATMENT?

Assisted Outpatient treatment is a sustained and intensive mandated treatment program based in the community for those who are experiencing severe mental illness. The program allows courts to order certain individuals, not voluntarily complying with treatment, to comply while living in the community (outpatient). AOT provides for strict eligibility criteria and an individualized treatment plan for each patient and with a case manager and procedures to monitor compliance. A hearing is held before a judge who ultimately determines whether court ordered treatment is warranted. The goal is to prevent a patient's condition from deteriorating to the point of an involuntary commitment thereby reducing hospitalizations and potentially dangerous acts by individuals.

A consideration of AOT is that individuals with disorders like schizophrenia often need medication to enable them to control their own thoughts and behavior. Therefore, as a result of their disorder, they may not recognize they are ill "Anosognosia" and see no need to be in treatment. The chart below reflects percentage of the severely mentally ill population experiencing Anosognosia and those often resistant to treatment due to lack of insight regarding their condition.

AFFECTED POPULATION CHART



The court order, as key component of AOT, not only commits the patient to accept treatment, the court order also commits the mental health system to providing treatment. The only service the patient is mandated to accept is case management. Medication is not forced as a part of AOT outpatient services. The treatment mechanism is only used until a person is well enough to maintain their own treatment regimen.

AB1421 (AOT) TARGET POPULATION

Eligibility criteria for AB1421 describe a population of adults with serious mental illness or experience repeated events and not engaging in mental health services on a voluntary basis. As noted above, a percentage of people with serious mental illness don't have awareness that they are ill and don't recognize the need for mental health treatment. This is more common in those with schizophrenia, bipolar, and other psychotic disorders. In addition, some adults with mental illness, specifically those with repeated crisis and hospital events, may have experienced trauma or stigma related to seeking or

receiving treatment and may avoid seeking or engaging in further mental health treatment. Further a subset of adults may experience difficulty accessing or navigating the mental health system as a result of barriers to access, limited resources or capacity issues or fall through the cracks when moving between levels of care. Many of these issues regarding availability of resources and transitions within the system were identified as areas for improvement for Santa Barbara County within the 2012 Tri-West Report.

HOW ASSISTED OUTPATIENT TREATMENT WORKS (EXCERPTS SUMMARIZED FROM AB1421 CHAPTERED)

AB1421 (AOT) ELIGIBILITY CRITERIA

AB1421 sets forth nine required eligibility criteria that must be met for enrollment in an assisted outpatient treatment program. A person may be placed in AOT only if after a hearing a court finds that all of the following criteria have been met:

1) Be 18 years of age or older.
2) Be suffering from mental illness.
3) Have a clinical determination that the person is unlikely to survive safely in the community without supervision.
4) Have a history of lack of compliance with treatment for their mental illness, in at least one of the following is true:
   a) At least two hospitalizations within the last 36 months
   b) One or more acts of serious and violent behavior towards themselves or another or threats or intent to cause serious physical harm to themselves or another with in the last 48 months.
5) Has been offered an opportunity to participate in treatment and plan by the director of the local mental health agency and the treatment plan includes all of the services described in section 5348 of the Welfare and Institutions Code and the person fails to engage in treatment.
6) The person's condition is substantially deteriorating.
7) Participation in AOT would be the least restrictive placement necessary to ensure the persons recovery and stability.
8) In view of the person's treatment history and current behavior, the person is in need of AOT in order to prevent relapse or deterioration that would likely result in grave disability or serious harm to self or others as defined as section 5150 of the Welfare and Institutions Code.
9) Be likely to benefit from AOT.

WHO CAN PETITION THE COURT FOR ASSISTED OUTPATIENT TREATMENT?

The process to both submit and review a petition for involvement in AOT is delineated in AB1421 and provides guidance for the overall process. Specifically, only the county mental health director, or their designee, may file a petition with the superior court in the county where the person is present or reasonably believed to be present.

However, the following people may request that the county health department investigate whether to file a petition for the treatment of an individual:

- Any adult with whom the person resides
- An adult parent, spouse, sibling, or adult child of the person;

- If the person is an inpatient, the hospital director;
- The director of a program providing mental health services to the person in whose institution the person resides
- A treating or supervising licensed mental health treatment provider; or
- The person's parole or probation officer.

Once receiving a request from a person in the categories above, the county mental health director is required to conduct an investigation. The director, however, shall only file a petition if they determine that it is likely that all of the criteria for an AOT petition can be proven by clear and convincing evidence. In addition, the availability of assisted outpatient services for the anticipated length of the order (up to six months) must be established by the court before ordering assisted outpatient treatment. It is anticipated that County Counsel will be of significant assistance in the initial phase of petition review to ensure that clear and convincing evidence standard is met before the petition for treatment is filed.

HOW LONG AFTER THE PETITION FILING IS THE HEARING?

The court must determine a date for a hearing on the petition that is no more than five days (excluding weekends and holidays) after the petition is filed. Continuances can only be allowed for good cause. Before granting a continuance, the court must consider the need for an examination by a physician, or the need to provide assisted outpatient treatment expeditiously.

WHO HAS TO BE NOTICED WITH A PETITION IS FILED?

The petitioner must ensure the petition and notice of the hearing is personally served on the person who is its subject. The petitioner also has to send notice of the hearing and a copy of the petition to:

- The county office of patient rights; and
- The current health care provider appointed for the person, if known.

The person subject to a petition may also designate others to receive adequate notice of the hearings such as family members or others supporting them in their recovery.

IS THE PERSON WHO IS THE SUBJECT OF THE PETITION REPRESENTED BY COUNSEL?

The person who is subject to the petition has the right to be represented by counsel at all stages of an AOT court proceeding. If the person elects, the court shall immediately appoint a public defender or other attorney to oppose the petition. If able to afford it, the person is responsible for the cost of the legal representation on his or her behalf.

WHAT IS THE SETTLEMENT AGREEMENT PART OF THE AOT PROCESS?

After an AOT petition is filed, but before the conclusion of the hearing, the person who is the subject of the petition may waive the right to a hearing and enter into a settlement agreement. If the court approves it, a settlement agreement has the same force and effect as a court order for assisted outpatient treatment. Settlement agreement must be in writing, agreed to by all parties and the court, and may not exceed 180 days. The agreement is conditioned upon an examining licensed mental health treatment provider stating that the person can survive safely in the community and also include a treatment plan.

WHAT HAPPENS AT AN AOT HEARING?

If after hearing all of the evidence, the court finds that the person does not meet the criteria for assisted outpatient treatment, the court will dismiss the petition. If the court finds, by clear and convincing evidence, that the person meets the criteria for AOT and there is no appropriate and feasible less restrictive alternative, the court may order the person to receive assisted outpatient treatment for up to six months.

HOW IS THE TREATMENT PLAN ACTUALLY DEVELOPED?

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

- That the ordered services are available from the county or a provider approved by the county for the duration of the court order;
- That the ordered services have been offered on a voluntary basis to the person by the local director of mental health, or his or her designee, and the person has person has refused or failed to engage in treatment;
- That all of the elements of the petition have been met; and
- That the treatment plan incorporated in the order will be delivered to the county director of mental health, or his or her appropriate designee.

CAN THE TREATMENT PLAN BE RENEWED?

If the condition of the person requires an additional period of AOT, the director may apply to the court prior to the initial order's expiration for an additional period of AOT of no more than 180 days (initial orders are for a period of up to six month). The procedures and requirements for obtaining a renewal order are the same as for obtaining an initial order.

CAN A PERSON BE RELEASED EARLY FROM THEIR AOT?

There are two methods by which someone under an order can establish that he or she no longer meets the eligibility criteria and should be released from an AOT order:

1) No less than every 60 days the director of the assisted outpatient treatment program is required to file an affidavit with the court stating that the person still meets the criteria for placement in the program. The person has the right to a hearing to challenge the assessment.
2) Also, the person can request a hearing at any time. At the hearing on this petition the court will determine whether or not the person still meets the initial AOT eligibility requirements. If not, the person shall be released from the AOT order. In either type of hearing the burden of proving that the AOT criterion is still met is on the director.

WHAT HAPPENS IF SOMEBODY FAILS TO COMPLY WITH AT AOT ORDER?

A licensed mental health treatment provider can request that one of certain designated classes of persons (peace officers, evaluation facility attending staff, members of mobile crisis teams, and other professional persons designated by the county) take a person under an AOT order to a hospital to beheld for an up to 72-hour examination to determine if he or she meets the criteria for inpatient

hospitalization (i.e., that the person is a danger to self/others or gravely disabled because of a mental illness). The treatment provider may only make such a request on determining that:

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

Any continued involuntary retention in the evaluating facility beyond the initial 72 hours must be pursuant to the California Code's provisions for inpatient hospitalization. A person found not to meet the standard for involuntary inpatient hospitalization during the evaluation period and who does not agree to stay in the hospital voluntarily must be released. Failure to comply with an order of assisted outpatient treatment alone is not sufficient grounds for involuntary civil commitment. In addition the non-compliance cannot result in a finding of contempt of court.

WHAT RIGHTS AND PROTECTIONS DO PERSONS SUBJECT TO THE PETITION HAVE?

A person subject to a petition for assisted outpatient treatment has the right to:

- Retain counsel or utilize the services of a court-appointed public defender;
- Have adequate notice of the hearings;
- Have 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 or her right to judicial review;
- 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 they waive the right;
- Appeal decisions, and to be informed of his or her right to appeal; and
- Receive the least restrictive treatment deemed appropriate and feasible.

ADDITIONAL REQUIREMENTS OF AOT

Prior to adoption of an AOT program, a county must take into consideration the many regulatory requirements stipulated in AB1421 and SB585. These regulatory requirements necessitate consideration ramifications of implementation. The following provides a basic outline of the necessary considerations.

COUNTY MUST OFFER THE SAME SERVICES ON A VOLUNTARY BASIS

A county that elects to develop an AOT program must offer the same services on a voluntary basis. This means that intensive services such as those provided in an AOT program cannot be reserved to those solely with AOT orders. Voluntary patients must also have access based on need to the higher intensity services equivalent to those dedicated to AOT. In addition a county that elects to develop an AOT program must show that it has adequate resources to offer extensive community support service options on a voluntary basis to individuals with psychiatric disabilities who would benefit from them. This includes the provision for "housing clients that is immediate, transitional, permanent, or all of these." For persons with children, they have a right "to live in a supportive housing environment that strives for reunification with their children or assists clients in maintaining custody of their children as appropriate."

COUNTY MUST ENSURE EFFECTIVE ASSISTANCE OF LEGAL COUNSEL AT ALL STAGES OF PROCEEDING

A person subject to a petition for AOT has the right to effective assistance of counsel. If the person chooses the court appoints the public defender or other attorney to assist the person. A person is required to pay the cost of legal services if he or she is able.

COUNTY MUST ENSURE THAT AOT SERVICES ARE CLIENT-CENTERED AND BASED UPON PSYCHOSOCIAL REHABILITATION SERVICES AND RECOVERY VALUES

The treatment strategy to be employed requires a written service plan and provision for services that are "client-directed" and that "employ psychosocial rehabilitation and recovery principles" which emphasizes services which support a person's potential for recovery. In addition each client "shall participate in the development of his or her personal services plan" and shall include other persons designated by the person.

COUNTY MUST INFORM PATIENT'S RIGHTS OFFICE OF AOT

The County Mental Health Director or designee must send a copy of the petition and notice of hearing on the petition to the person subject to an AOT petition and to the county office of patient rights. Patient's Right's offices will need to be funded to respond to such notifications and potential petitions.

COUNTY MUST DEVELOP AND PROVIDE A TRAINING AND EDUCATION PROGRAM

A county that elects to develop an AOT program must in collaboration with "client and family advocacy organizations, and other stakeholders," develop a training and education program for purposes of delivery of services to persons who are subjected to, or at risk of being subjected to, the AOT program. Training shall be provided to mental health providers, law enforcement officials, and certification hearing officers, among others. Training shall include legal requirements for involuntary inpatient and outpatient treatment, including with respect to determining if a person is considered to be gravely disabled. Training must also I include methods for ensuring that decisions regarding involuntary treatment direct patients toward the most effective treatment. Training shall include an emphasis on each patient's right to provide informed consent to assistance."

WHAT TYPES OF SERVICES MUST A COUNTY PROVIDE TO HAVE AN AOT PROGRAM?

The service requirements set for AOT are set forth in AB1421 and outlined within the Welfare and Institutions Code Section 5348 and summarized in following:

1) Community based mobile multidisciplinary highly trained mental health teams that use high staff to client rations of no more than 10 clients per team member.
2) A service planning and delivery process that includes provisions to determine the numbers of persons to be served and the programs and services that will be provided to meet the individual needs. The threshold of services must include:
   - Outreach and engagement services to reach families and support systems
   - Coordination and access to medication, psychiatric and psychological services and substance abuse services
   - Vocational rehabilitation
   - Veterans' Services
   - Services to physically disabled
   - Supportive housing or other housing assistance

- Removal barriers to services resulting from cultural background, linguistic skills, racial, age of gender differences
- Those at risk of homelessness
- Services to older adults person who are physically disables and seriously mentally ill young adults (25 years of age or younger) who are at risk of becoming homeless
- Housing that is immediate, transitional, permanent or all of these.
- Needs of women from diverse backgrounds

3) Personal Service Coordinator who may be a part of the APOT program team who are responsible for ensuring, to the extent feasible that people subject to AOT receive services that are age, gender and culturally appropriate and enable them to:
    - Live in the least restrictive housing feasible in the local community
    - Engage at the highest level productive activities appropriate to the abilities and experience
    - Access appropriate education and vocational training
    - Access physical health care; and
    - Reduce anti-social or criminal behavior

HOW DOES AOT DIFFER FROM OTHER PROGRAM MODELS

Component	ACT	ACTOE	FSP	AOT
Low Client Ratio	✓	✓	✓	✓
Team-Based Care	✓	✓	✓	✓
All MH Services	✓	✓	✓	✓
Substance Abuse Tx	✓	✓	✓	✓
Field-Based	✓	✓	✓	✓
Housing Svc	✓	✓	✓	✓
Vocational Svcs	✓	✓	✓	✓
Cultural Competence	✓	✓	✓	✓
Wellness / Recovery	✓	✓	✓	✓
24/7 Response	✓	✓	✓	✓
Peer Members	✓	✓	✓	✓
Flex Funding			✓	✓
Physical Housing			✓	✓
Extended Outreach & Engagement		✓		✓
Specialized Svcs (Age, Gender Etc.)				✓
Court Process/Order				✓

FULL SERVICE PARTNERSHIP

The use of Full Service Partnership is a required category of service described in the MHSA as a "to do whatever it takes" model to support individuals with serious mental illness. The FSP model which the County of Santa Barbara currently employs involves a collaborative relationship between the county and consumer so that the consumer can achieve the goals identified in their individual services and supports plan. The full spectrum of services includes a variety of mental health and non-mental health services (i.e., housing, food, and clothing) as well as additional supports.

ACT/ACTOE

ACT services are provided in Santa Barbara County using a multi-disciplinary team approach. Each team includes staff members from different mental health care specialties who work closely with the client to provide comprehensive services. Team members consist of a psychiatrist, nurse(s), and other professionals including vocational, family, wellness, and substance abuse treatment specialists. Many teams also include a peer specialist. Because team members share responsibility for providing treatment and rehabilitation services, the entire team supports each client's personalized goal of recovery.

With staff of diverse specialties and a low client to staff ratio of ten to one, ACT teams are able to provide tailored, individualized services to clients. Since clients typically receive services from each staff member on the team, care is continuous and coordinated, even if someone is on vacation or leaves the team. Further, ACT services are delivered primarily in community settings of the client's choice, including client homes, workplaces, parks, recreational sites, and other locations. Service delivery in the community makes getting treatment easier and more convenient for clients.

Supporting client choices for their recovery is a major value of ACT services. Treatment plans are developed collaboratively by the team and client based on the individual's strengths, needs, desires, goals and culture. Treatment plans are modified as needed through ongoing assessment and goal setting. ACT teams meet daily to discuss each client's progress, allowing the team to plan or quickly adjust the services to meet clients' needs.

ACT teams deliver mutually agreed upon services and support each client's need to live successfully in the community and reach his or her recovery goals. Vocational specialists assist clients to participate in community employment and educational opportunities by providing related rehabilitation and support services and substance abuse specialist's work with the client to provide integrated services.

WHAT ARE THE ARGUMENTS FOR AND AGAINST ADOPTION OF AOT?

AOT is a much debated topic among a variety of stakeholder groups and advocacy organizations. The key arguments are consolidated into the following points:

Opposition:

- Concerns about potential abuses of the process of involuntary commitment
- Non mental health professional at the courts involved in treatment process
- Concern for consumer rights and personal decisions made regarding care
- Quality intensive voluntary treatment proven effective (FSP, ACT). Efficacy of Court order questioned
- AOT may strain unfunded mental and systems and directs resources to small population of those in need

Proponents:

- Subgroups of adults with serious mental illness do not recognize illness and therefore do not engage in services
- There are limited options to engage adults with serious mental illness not voluntarily
- Court system mandates the treatment and provides oversight
- Provides critical intervention to those at risk of homelessness, violence, incarceration of death
- May save money by replacing high cost services with lower cost community based treatment
- Engages individual and support system in individualized treatment plan

FUNDING CONSIDERATIONS

AOT FUNDING SOURCES

AOT has two main categories of service costs. This includes the costs associated with mental health services and the costs associated with the legal system, including the court, public defender, and county counsel. In 2013, Welfare and Institutions Code Section 5349 was amended to clarify that MHSA money can be used for court ordered AOT Services. Medi-Cal and Medi-Care revenue may also be used to offset the cost of treatment and certain forms of housing. MHSA funds may be used through Full Service Partnership programs and ACT services to fund treatment and housing pertaining to AOT. If a Board of Supervisors adopts AOT, which results in a utilization of existing Full Service Partnership programs and available ACT spaces, a community program planning process is required. The County of Santa Barbara MHSA 2015/16 Plan amendment process is anticipated to begin in July of 2015.

Category	Allowable Funding Sources
Full Service Partnership (FSP) Services	Any funding source that currently funds FSP/ACT services, including MHSA. If FSP services were to be funded by MHSA: ➢ A plan update would be required and include a CPP process, 30-day public posting, public hearing, and Board of Supervisor approval. ➢ The costs associated with AOT implementation cannot reduce or eliminate voluntary programs. (i.e., must be monies not currently allocated to existing programs.)
Housing	MHSA funds for housing associated with FSP participation, MHSA housing, or other non-mental health housing subsidies.
County Counsel	General Fund or other non-mental health funding ➢ MHSA and/or Realignment funds cannot be used for legal costs associated with AOT implementation.
Public Defender	General Fund ➢ MHSA and/or Realignment funds cannot be used for legal costs associated with AOT implementation.
Court	General Fund ➢ MHSA and/or Realignment funds cannot be used for legal costs associated with AOT implementation.

THE RESEARCH

Randomized control studies are studies in which individuals are randomly assigned to receive an intervention, in this case court order, or no intervention, treatment with no court order, and followed over the course of time. In a review of the randomized control study literature research, no evidence was found to indicate that a court order is necessary or produces treatment compliance or that the court order in and of itself has an independent effect on client outcomes. Research does indicate that intensive long term treatment, such as adequately resourced Assertive Community Treatment Programs and Full Service Partnerships with intensive treatment components play a key role in improved clinical outcomes. A sampling of randomized control studies reviewed is attached to the appendix of *The Feasibility Analysis of AOT Implementation in Santa Barbara County Report*.

However, within California multiple non-randomized research studies have been conducted to determine the effectiveness of AOT programs. Generally, findings suggest that AOT demonstrates positive outcomes for clients and yields cost savings. As an example, the Los Angeles County AOT pilot program report indicates that incarceration was reduced by 78% and hospitalizations were reduced by 86%, as a result of AOT. A sampling of non-randomized studies reviewed is attached to the appendix of *The Feasibility Analysis of AOT Implementation in Santa Barbara County Report.*

Outside of California, New York's assisted outpatient treatment law, commonly known as Kendra's Law has been the subject of two key investigations. While not randomized controlled studies, a 2005 study conducted by the New York State Office of Mental Health (OMH Study) and a 2009 evaluation performed under a contract with New York State by an independent research team were conducted. The studies report that AOT reduces hospitalization homelessness, arrests and incarceration among people with severe psychiatric disorders, while increasing adherence to treatment and overall quality of life. The evaluations further note that the effectiveness of Kendra's Law is not simply a product of a systemic service enhancements but rather attributed to the court ordered component of AOT in motivating treatment compliance. Further, the Duke Study referenced within the text of AB1421 noted the positive effect of sustained outpatient commitment, coupled with intensive mental health services, especially with those experiencing schizophrenia and other psychotic disorders.

WHAT ARE OTHER COUNTIES DOING TO ADDRESS SERVICE NEEDS?

In a survey conducted by Contra Costa County of all 58 counties it was determined that 26 are not pursuing implementing AOT at this time. Nine counties have decided not to implement AOT, but have or are working to enhance their voluntary services for the most severely mentally ill by establishing programs that meet the minimum standards for ACT level of services. Other counties are reviewing conservatorship programs and opportunities to maximize intensive outreach in other service areas. Reason provided for not implementing AOT included:

- Preferred increase in voluntary services
- Lack of funding
- Court systems were not capable of handling the workload

Thirteen counties are considering implementation including Santa Barbara County. Nevada County has extensive experience implementing AOT. Recently the Board of Supervisors' of Contra Costa, San Francisco, Orange, and Los Angeles, Placer, and Mendocino counties have passed resolutions or

ordinances adopting AOT and directed their respective Behavioral Health Departments to develop and implement appropriate AOT programs. Alameda County declined implementation It should be noted that each county implemented a pilot program prior to full implementation of AOT. Typically counties have pursued a pilot program in some from before full implementation

ASSESSMENT OF AOT IMPLEMENTATION IN SANTA BARBARA

While Santa Barbara County has implemented FSP, ACT, and ACTOE which have many of the services required by AOT, several required services are lacking. Many of the existing programs meet threshold requirements; however, in order to fully implement AOT, the gaps in services must be addressed. This disparity of services and costs associated with the services has been built into the FSP rates for the analysis of costs associated with AOT. In addition, specialty programming for women and children, and the disabled was calculated for a percentage of the possible AOT participants. Finally a range of housing costs were estimated to serve an AOT program. Housing costs added to the program analysis including cost of single occupancy apparent ($1,220 per month) and Board and Care at a net cost of $8,200 annually and one Institute of Mental Disease Bed was considered at a cost of $100,000 annually. Many of the AOT program mandates currently lacking within the system were identified as areas for improvement in the TriWest Report. The following chart represents each of the required provisions of AOT and the current availability within Santa Barbara County Alcohol, Drug, & Mental Health Services System of Care. The narrative following describes the services within the Santa Barbra County system of care.

AOT Laura's Law Requirements	Santa Barbara Availability
•Community-Based Services (low client-to-staff ratio)	Yes (ACT 275 slots)
•Specialized Care (Recovery Principles):	
Outreach and engagement	Partial (ACTOE 15 slots)
Medication support	Yes
Crisis response	Yes
Substance abuse treatment	Yes
Supportive housing	Partial (Systems Change)
Vocational services	Yes
Cultural competence	Partial (Systems Change)
Peer & family involvement	Partial (Systems Change)
72-hour 5150 assessment	Yes
•Specialized Services for:	
Persons with physical disabilities	Partial
Older adults	Being Implemented
Young adults	Yes
Women from diverse cultures, w/ children	No
•Provision for Housing	Very Limited
•Early Intervention for those at Risk of Homelessness	Limited

COMMUNITY BASED SERVICES WITH 10:1 CLIENT RATIO (YES AVAILABLE):

Intensive community based wrap around services teams are in place and functioning within Santa Barbara County. The 10:1 client ratio is considered a best practice and goal for this type of treatment. However the ratio is not mandated. Both ACT and ACTOE teams throughout the County may or may not reach the 10:1 client ratio given the changing needs of the system. However for the proposed of AOT a strong foundation exists on which to build high impact teams and attain the 10:1 client ratio mandate. This may be achieved via implementing the findings of the Tri West Report in which it was noted those with less intensive needs should be reevaluated to determine need for ACT programs. Fully assisting the overall ACT and ACTOE clients to transition to a more appropriate level of care must be considered prior to bolstering ACT and ACTOE services for the purposes of implementing AOT.

INTENSIVE OUTREACH AND ENGAGEMENT (YES, PARTIALLY AVAILABLE)

Intensive Outreach and Engagement is presently offered as a component of the ACTOE teams. Five ACTOE slots in each of three regions of the County presently exist. Intensive outreach and engagement involves active and consistent efforts made to connect with individuals (many whom may be believed to meet the same or similar criteria of AB1421) to engage them in necessary treatment.

MEDICATION SUPPORT (YES AVAILABLE)

Medication support is a component of each of the ACTO and ACTOE team. Medication support services involve the assessment for need of medications, medication management and ongoing monitoring of medications needs, impact and side effects.

CRISIS RESPONSE: (YES, AVAILABLE)

Crisis response involves intervention for an individual who is believed to be an imminent risk to themselves, someone else or gravely disabled as result of a mental health condition. The crisis response intervention aims to assure the individual is safe and able to receive the necessary treatment to relieve their immediate acute psychiatric symptoms. These services are currently offered via CARES as well as the recently implemented crisis triage and mobile crisis teams. In addition both the crisis stabilization unit and residential respite facilities are scheduled for opening summer of 2015 which will further enhance resources within the crisis system.

SUPPORTIVE HOUSING: (LIMITED AVAILABILITY)

Supported Housing Service (SHS) teams are located in Santa Maria and Santa Barbara each serving a capacity of 130 individuals per team. The Supported Housing teams are staffed very similarly to that of the ACT teams and provide a very similar type of service to aid individuals to live within the community. The SHS provides a lower level of service amount and intensity than ACT as the needs of the individuals served in this program are higher than could be met by traditional outpatient case management, but lower than that required by ACT. SHS is often used as a step down model from individuals previously served in the ACT program.

VOCATIONAL SERVICES (YES, AVAILABLE)

Vocational services are offered through Rehabilitation Specialists. While many high intensity teams (such as ACT and SHS) have rehabilitation specialists on their teams, ADMHS also works through a cooperative agreement with the Department of Rehabilitation to provide a variety of vocational resources to help individuals attain vocational employment and/or supports within the community.

CULTURAL COMPETENCE (PARTIALLY AVAILABLE, SYSTEMS CHANGE)

It is a stated goal of the Systems Change vision and guiding principles to operate a culturally competent and culturally capable system. To support this effort, the department leads a Latino Advisory Committee and Cultural Competency Action team. Both of these groups provide steering and direction to the department's efforts to assure a culturally competent system of care. With the oversight of DHCS, ADMHS provides a variety of mandatory cultural competency trainings for staff and contract providers throughout the system. Current initiatives include the recent hire of a Spanish translator for written documents, development of an assessment tool to include within all clinical assessments which is culturally focused, and focused outreach efforts to a variety of underserved cultures within the community. A focal point of system change is integration of culturally competent principles of service in all facets of service delivery to ensure the system is welcoming and service ready for all. The intake assessment tool for all that enter the ADMHS is being modified to places enhanced attention on the cultural, linguistic age and gender specific needs of individuals in order to appropriately tailor treatment plans and devise effective systems of support. This intake and assessment tool has been completed and should be integrated into our system by May of 2015. Training on the development of culturally appropriate assessments is also part of this initiative and will be incorporated into our existing training plan for ADMHS.

PEER AND FAMILY INVOLVEMENT (PARTIALLY AVAILABLE, SYSTEMS CHANGE)

The involvement of peers and family holds a great importance within ADMHS system change. The employment of peers within the ADMHS system has increased considerably over the years. ADMHS presently employs over 40 peers within the system and is establishing protocols for integration of peers into all facets of the service delivery system. Support for peer specialists is increasing and strategies for ongoing supervision, assistance with integrating into more 'clinical settings,' training and certification, and career ladders are currently under development as a focal point of System Change.

72-hour 5150 Assessment (Yes, Available)

ADMHS provides 5150 (adults) and contracts with SAFTY to provide 5585 (minors) for persons in the community believed to be imminently at risk to self, others or gravely disabled as result of a mental illness. CARES Mobile provides response throughout the community for adult 5150 evaluations through teams located in each region of the county (Santa Barbara, Lompoc and Santa Maria). SAFTY provides response for community minors who require a 5585 evaluation, and also have teams located throughout the county.

SPECIALIZED SERVICES FOR:

PERSONS WITH DISABILITIES

Santa Barbara County provides specialty mental health services to those who meet medical necessity criteria including Seriously Mentally Ill (SMI) and Seriously Emotionally Distributed (SED). If a person has a co-occurring physical or developmental disability, ADMHS continues to treat the mental health needs and work collaboratively with physical health care or developmental center resources and providers to provide comprehensive care.

Older Adults

All adult programs serve adults of all ages, including older adults. Many of the County of Santa Barbara teams have case managers who work directly with Public Health to best serve those with co-occurring physical health care needs.

Younger Adults

Transition Age Youth Divisions are available countywide. The TAY teams provide screening, identification and treatment for TAY experiencing prodromal symptoms of psychosis or first episode psychosis. The TAY teams also provide care for TAY who are transitioning between the children's and adults system. TAY programming ranges from traditional outpatient mental health services to case management in the field, vocational services and day programming for these young adults.

Women of diverse Cultures and with Children

Santa Barbara County provides specialty mental health services for individuals who meet medical necessity, seriously mentally ill or seriously emotionally disturbed. Understanding the unique needs of women of diverse cultures and with children is initially being addressed through revising intake procedures. Intake, and the findings which result, are essential to the development of an effective treatment plan. It may be necessary to engage a community based organization to provide certain services in this area. Costs have been added in the analysis for potential services in this area

Provision for Housing

As noted, housing for clients of ADMHS is currently very limited. Within the system ADMHS, and community based organizations, to create linkages to housing yet all are challenged due to lack of units. Existing housing stock, transitional and permanent, is typically full. Currently the department is working to enhance immediate availably by adding 12 new licensed residential units in cooperation with existing service providers. In addition ADMHS is working with the Housing Action Team to identify the number and types of units most in need by ADMHS clientele. The costs for securing additional housing is identified within the options noted within the report. This includes apartments, board and care and institutes for mental disease.

Early Intervention for those at risk of being homeless

Through MHSA, Santa Barbara County has several Prevention and Early Intervention (PEI) programs available. The average age of the onset of mental illness is 16-25 at which time services to identify the onset of mental illness become all the more critical. The lack of identification can lead to homelessness and other challenges. In addition, individuals with criminal offender histories and mental health conditions are also at greater risk of homelessness. ADMHS works closely in collaboration with the Probation Department and the Sheriff's Department to provide intervention, services and prevent homelessness. Homeless outreach teams aim to connect with individuals to prevent ongoing homelessness and aid with connection to services as well as housing resources. Lack of appropriate transitional and permanent housing limits the effectiveness of this area.

Santa Barbara County's Potential AB1421 Eligible Population

Projecting the number of people who may qualify for AOT programs requires estimating the number of people who are likely to meet eligibility criteria previously mentioned. While some criteria are clear, such as being over 18, some criteria are predictive and less easily estimated. Clients must meet all criteria in order to be eligible for the AOT process. AOT eligible clients must be 18 years of older with a serious mental illness and lack of treatment compliance. In addition they must have had at least two

psychiatric hospitalizations (in a county, state or federal facility) within 36 months of evaluation for AOT, and at least one episode of threats or actual violent behavior towards themselves or others within 48 months of AOT evaluation. In addition, evaluation of potential AOT clients must demonstrate that the client has been given every opportunity to participate in a treatment plan, but they continue to fail to engage in treatment, resulting in the client's condition substantially deteriorating due to lack of treatment engagement. AOT eligibility is also contingent upon demonstrating that participating in AOT would benefit the client by providing services in the least restrictive setting possible, and that the provision of AOT services would result in preventing relapse and/or deterioration to grave disability or serious harm to self or others.

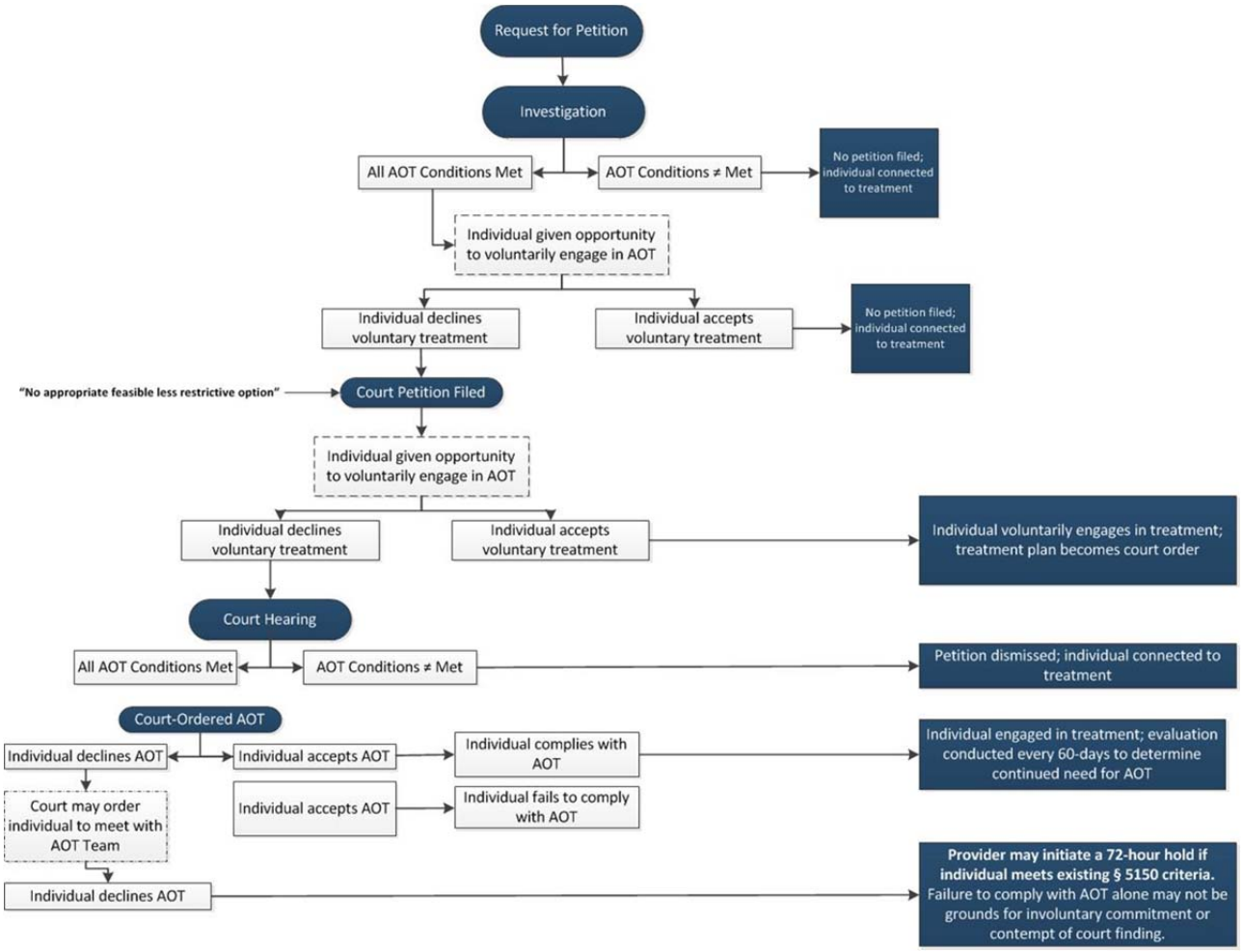
In order to estimate the population of individuals within Santa Barbara County who would likely meet the specified criteria, April Howard, PHD of ADMHS applied the methodology that New York State, other states and other California counties used, which was 1 Laura's Law eligible AOT client per 25,000 residents. According to US Census, there are approximately 431,244 residents in Santa Barbara County. Applying the 1 per 25,000 residents' results in approximately 17.25 potential clients served per year under Laura's Law via AOT. It is acknowledged that there is likely a backlog of clients in the system such that the first year of a program may see a higher volume of clients, closer to 17-20. Subsequently, it is estimated that the annual number served may be less than 17, perhaps closer to 10 annually.

The second approach to identify the estimated eligible population was an analysis of existing clients known to staff in Santa Barbara County's system. Based on the review of current Alcohol, Drug, and Mental Health Services caseloads, conducted by April Howard, PhD of ADMHS, it was determined that as of March 2015, 75 known individuals within Santa Barbara County may likely meet the screening criteria for AOT. Of these individuals, based on a review of the experience of both Nevada County, Contra Costa County, and Orange County it is anticipated that 38 will voluntarily engage in services and 37 will require some form of involuntary court ordered treatment services. This is a working estimate which may change.

ANALYSIS OF COSTS OF PROGRAM

The following chart provides an conceptual overview of the AOT process beginning with the request for a petition, and estimated voluntary engagements at various times within the process to ultimately determine how many individuals may actually engage in the court ordered process. This exercise aids in estimating overall costs for program implementation for both voluntary and actual court ordered treatment. Ultimately, the overall cost must include the same services delivered to those who engage in the treatment process voluntarily as those who activate court ordered treatment component of AOT.

THE PROCESS



WHAT ARE THE COSTS TO IMPLEMENT AOT?

In order to ascertain the full costs of AOT implementation, the CEO's Office worked closely with ADMHS fiscal staff to ascertain the present costs of existing services and programs as well as the current revenue generation rates (Medi-Cal, Medi-Care) applicable for the services mandated for AOT. Multiple counties including Nevada, Orange and Contra Costa were consulted regarding program development recommendations, revenue and housing assumptions, and overall approach. Based on this information, key program elements were quantified and the following two possible implementation scenarios were developed. Each scenario contains the following recommended components sized to meet the needs of the AOT population referenced in each option:

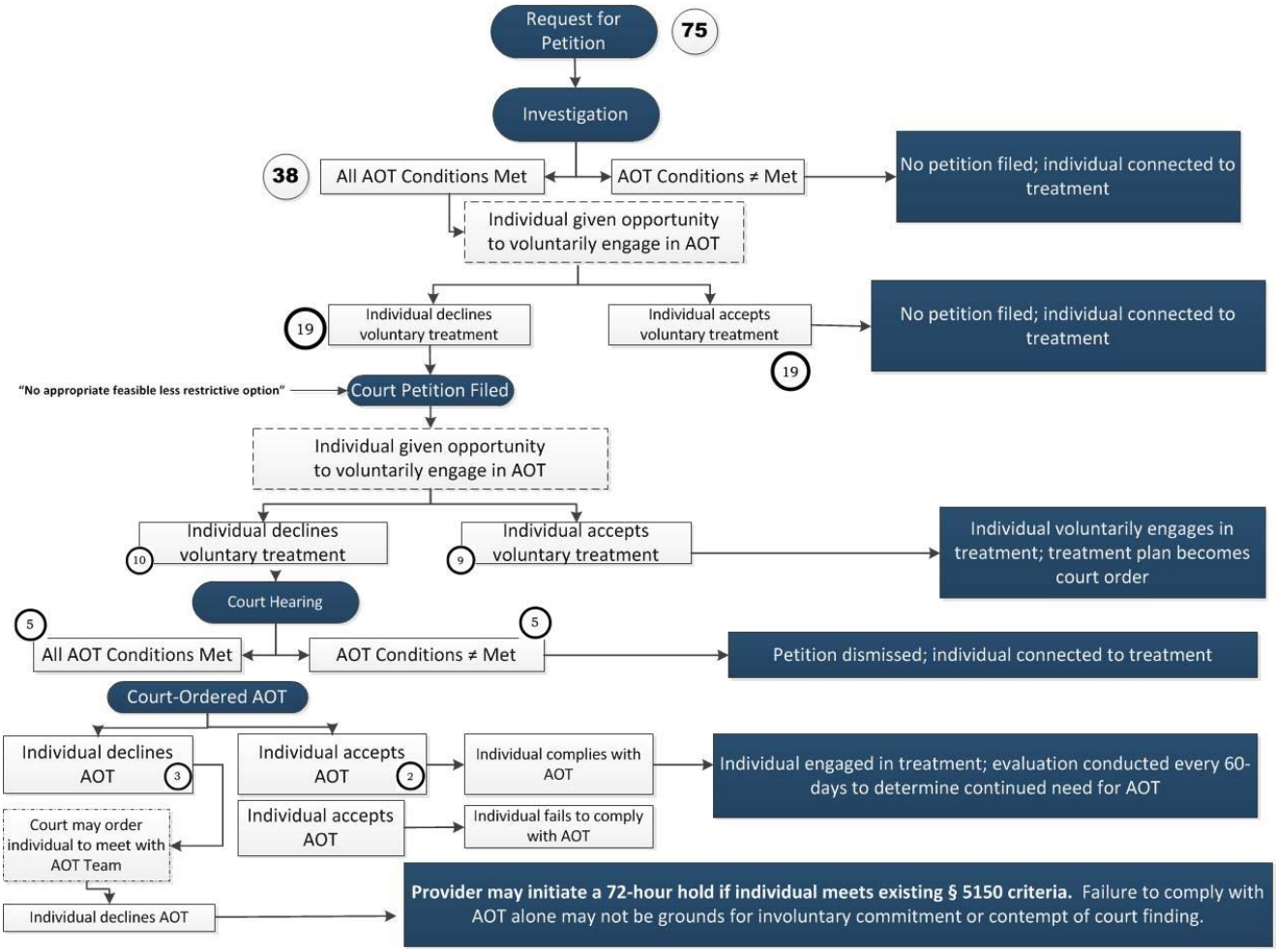
- System navigator (oversight of process)
- Appropriate level of dedicated staff for program implementation
- Inclusion of all administrative and startup costs
- External evaluation costs
- Funding for legal staff (County Counsel and Public Defender and Courts

- Full cost for a robust FSP slots which meet the program standards for AOT (housing costs calculated separately)
- Medi-Cal revenue calculated on assumption that 80% of individuals would provide Medical and 60% of the costs incurred would be reimbursed (current revenue recovery rates)
- Housing would be required by 50% of the AOT participants (range of housing costs included from single family with an escalator for multifamily as well as Board and care)
- Costs to provide "gap" beyond FSP services not currently in place in Santa Barbara County and required to meet AOT criteria
- MHSA potential funding source with community plan update in 2015/2016

In addition, on March 24, 2015 the Board of Supervisors adopted the MHSA Plan Updated for 2014/2015. This included the provision of Full Service Partnership services within Lompoc, Santa Maria, and Santa Barbara, and supported Housing North and South FSP. From July 2013 to June 2014, these programs collectively provided services to over 470 individuals. The FSP's however contain minimal funding for housing. To ensure the appropriate level of housing is provided, per the AB1421 requirements, costs for varying levels of housing are included in both options. Further, Welfare and Institutions Code Section 5349 indicates that a Board of Supervisors must make a finding that no voluntary mental health program serving adults and no children's mental health program may be reduced as a result the implementation of this article. In regards to treatment spaces, it is anticipated that with anticipated movement of clients within FSP and ACTOE programs, individuals engaging in AOT services will be able to utilize slots provided via MHSA funds as they become available through client transition. Given the 470 slots available this level of transition is highly likely.

With these assumptions in place the following options were developed:

OPTION 1 FULL IMPLEMENTATION 75 PERSONS SCREENED



Program Costs (Itemized)	Cost	Notes
Total Salaries & Benefits	303,325	1 FTE Psychologist/1 Psych Tech/.25 Clerical
Total Services & Supplies	87,642	Contract Evaluator $40,000
Total Start Up - Capital Assets & Facility	180,000	Vechicles & facilities
Total Administrative Costs	85,645	
Total Legal and Court Costs	265,000	.6 Counsel/.3 Defender, Courts/ .5 paralegal, .5 LOP
Housing - Single Bedroom Apartments	150,000	
Housing - IMD Step Down Cost	100,000	
Housing Board and Care	66,240	
Enhanced Programming	124,000	Gap in services identified.
FSP Net Cost Vol	282,420	
FSP Net Cost Invol	282,420	
Total Net Program	**1,926,691**	
FSP Treatment Revenue	260,695	Medi-Cal Reimbursement
Enhanced Programming Revenue	76,000	Medi-Cal Reimbursement
Total Gross Program	**2,263,387**	
Total Cost Per Client	**30,178**	75 starting, average cost

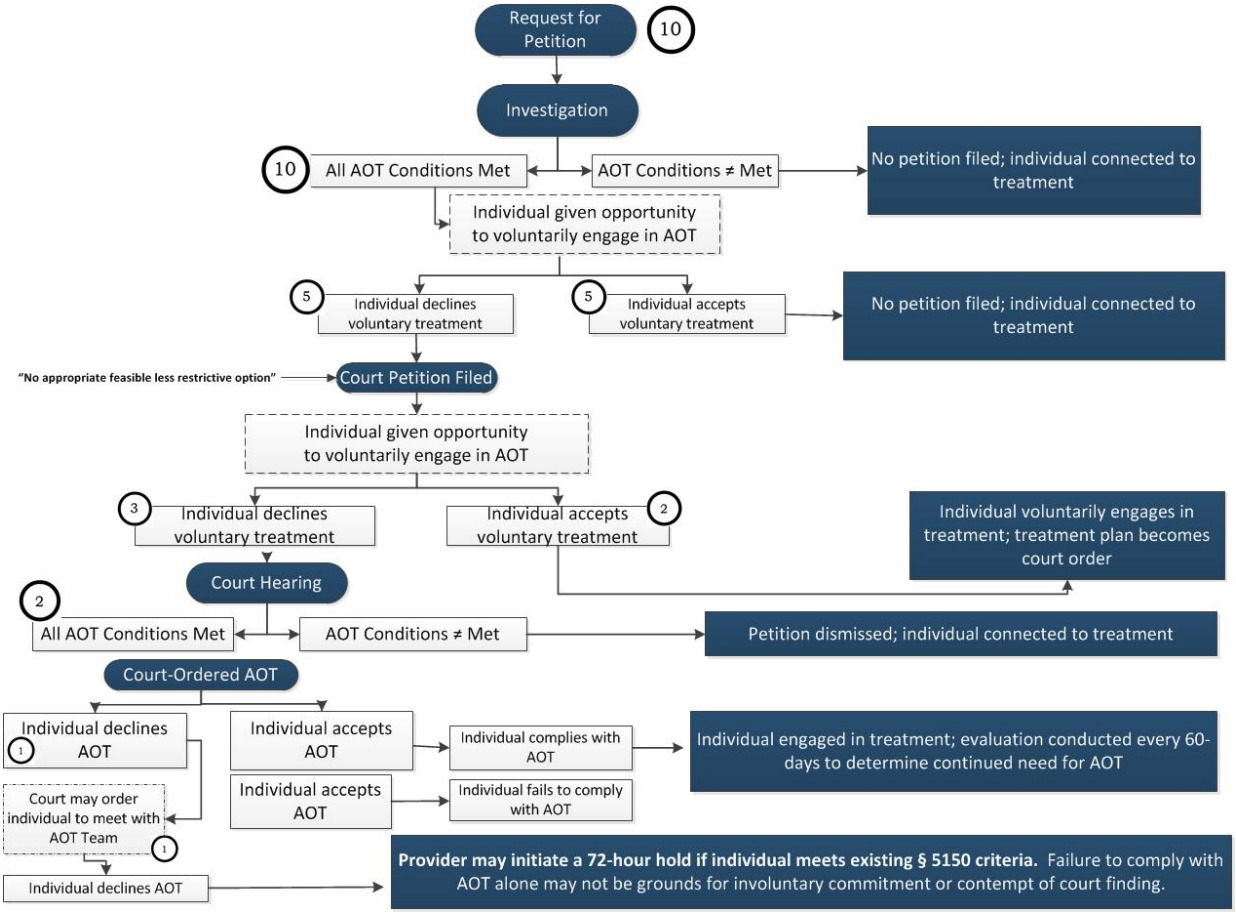
Funding Opportunities 75 person Pilot	$
MHSA Eligible Costs (with MHSA Plan review process)	1,345,452
Non MHSA Funds (General Fund)	265,000
Non MHSA Housing needs: Current funds fully utilized for existing FSP clients – non MHSA funds needed (General Fund)	316,240
FSP Treatment Revenue	260,695
Enhanced Program Revenue	76,000
Total	2,263,387

This option considered full implementation is designed to evaluate 75 individuals for AOT services. Anticipating that 50% of the individuals would meet all nine criteria for AOT, the program would serve 38 individuals. Of the individuals meeting all criteria it is anticipated that 50% (19 persons) will voluntarily participate in treatment services with the remainder (19 persons) would engage in the assisted outpatient court ordered process to receive services. The total cost to implement a program of this size is $2,263,387. The program may be funded via MHSA, Medi-Cal, Medi-Care and non-Mental Health Services monies (i.e., general fund). Should this option be pursued it is highly recommended that partial staffing be considered as a part of the budget process to facilitate program design, evaluation parameters and community outreach. This would entail .5 Psychologist, .25 of clerical, and $10,000 for the contract evaluator and general operating needs. Total cost estimated for 2015/16 budget is $121,000. General Fund would be necessary in 2015/16. However, in all future years, staffing associated with program implementation could be included under MHSA. Other factors considered in the development of the estimate include:

- Net Cost for FSP assumes 48% reimbursement (20% are indigent and then 80% have Medi-Cal with 60% reimbursement of those costs)
- No net cost for IMD step down. This is only calculated as Gross. Assume Crisis Residential at contract rate of $100k/yr.
- Costs for Single Bedroom Apartment, assume $1250 per studio per month
- Legal costs of County Counsel, Public Defender and Courts System included at .6 Deputy County Counsel
- Cost per person $30,178 AOT for 75 individuals

In a review of the costs of the top 75 utilizers within the ADMHS system it was determined that in 2014 $6,653,900 was expended on inpatient and outpatient services. On average the annual cost per individual user was $88,719.

OPTION 2 10 PERSON PILOT: 10-PERSONS SERVED



Program Costs (Itemized)	Cost	Notes
Total Salaries & Benefits	92,520	.5 Psych/.23 Clerical
Total Services & Supplies	52,642	Contract evaluator $10,000
Total Start Up - Capital Assets & Facility	3,000	
Total Administrative Costs	22,224	
Total Legal and Court Costs	10,000	
Housing - Single Bedroom Apartments	30,000	
Housing - IMD Step Down Cost	100,000	
Housing Board and Care	8,260	
Enhanced Programming	18,600	Gaps in services identified
FSP Net Cost voluntary	74,321	
FSP involuntary	74,321	
Total Net Program	**485,888**	
FSP Treatment Revenue	137,208	Medi-Cal Reimbursement
Enhanced Programming Revenue	11,400	Medi-Cal Reimbursement
Total Gross Program	**634,496**	
Total Cost Per Client	**63,450**	10 person pilot cost per person

Funding Opportunities: 10 person Pilot	$
MHSA Eligible Costs (with MHSA plan review process)	337,626
Non MHSA Funds: (General Fund)	10,000
Non MHSA Housing needs: * Current funds fully utilized for existing FSP clients non MHSA funds needed (General Fund)	138,262
FSP Treatment Revenue	137,208
Enhanced Program revenue	11,400
Total	**634,496**

This option provides for a small yet meaningful pilot program designed to serve 10 individuals. It is anticipated that 50% of the individuals will voluntarily engage and 50% will engage through the assisted outpatient court ordered process. The total gross cost to implement a 10 person pilot is estimated at $634,496. This program may be funded via MHSA, Medi-Cal, Medi-Care, and non-Mental Health monies such as general fund. Should this option be pursued it is highly recommended that partial staffing be considered as a part of the upcoming budget process to facilitate program design, evaluation parameters and community outreach. This would entail .5 Psychologist, .25 of clerical and $10,000 for the contract evaluator and general operating funds. Total costs estimated for 2014/15 budget is estimated at $121,100. General Fund would be necessary in 2015/16. However, in all future years, staffing associated with program implementation could be included under MHSA. These costs resemble the full program cost as the level of effort to design both the pilot and full program are relatively similar. Additional considerations for the program estimates include:

- Net Cost for FSP assumes 48% reimbursement (20% are indigent and then 80% have Medi-Cal with 60% reimbursement of those costs)
- No net cost for IMD step down. This is only calculated as Gross. Assume Crisis Residential at contract rate of $100k/yr.
- Costs for Single Bedroom Apartment, assume $1250 per studio per month
- Cost per person $63,450 for 10 persons

Cost of Legal Counsel i.e. County Counsel, Public Defender and Courts scaled to pilot size and scope. Given size it is anticipated that much of the work of 10 persons served can be absorbed with existing resources. Approximately $10,000 is provided for unanticipated needs.

In a review of the costs for the top 10 utilizers within the ADMHS system it was determined that in 2014 $1,658,900 was expended on inpatient and outpatient services. On average the annual cost per individual user was $165,890.

OPTION 3: NO IMPLEMENTATION - SYSTEM STABILIZATION - REEVALUATE

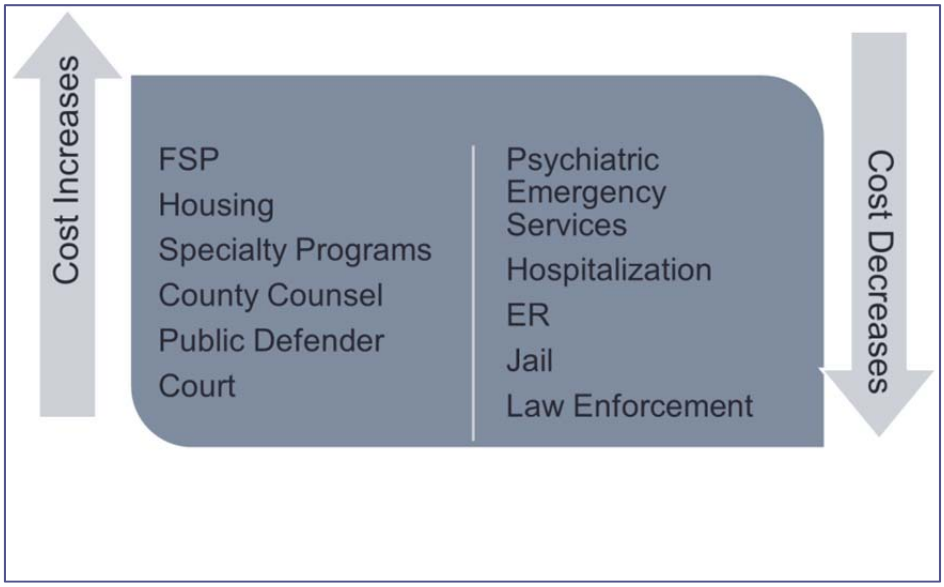
This option addresses the capacity of the department to implement an additional program given the multiple system change activities currently underway within the ADMHS Department and the ongoing efforts to balance, stabilize, and enhance the system of care. As previously reported to the Board, key staffing needs and program activity anticipated as part of the 2014/15 budget are not complete and the system of care remains out of balance with rising costs within the inpatient system. Key programs and

services in development or recently implemented as referenced in the 2014/2015 Budget Adoption materials and the MHSA Plan include:

- Expand the outpatient system of care
- Expand Justice Alliance
- Expand forensic team
- Expand Homeless outreach services
- Enhance Cultural Competency throughout all programming
- Establish safe and stable housing
- Maximize and endure the fidelity ACT and FSP programming
- Complete implementation of the crisis triage, crisis respite, and crisis stabilization facilities

WHAT ARE THE COST SAVINGS ASSOCIATED WITH AOT?

While it is reasonable to anticipate cost savings as a result of implementing AOT in Santa Barbara County, there is not adequate information from comparable California counties to reliably quantify or estimate what the actual cost savings would be. The only county with actual cost savings data is Nevada County ($1.81 per every $1.00 spent on the program). It is unlikely that these costs and cost savings would be applicable to Santa Barbara County given the difference in size and complexity of program. Many counties have not attempted to estimate cost savings or cost avoidance with any detail when considering AOT, but are collecting data, as required by the State Department of Health Care Services, to assess actual cost savings after the first year of implementation. In discussions with Orange County, it was indicated that they expect the cost savings from AOT to be similar to the cost savings associated with FSP services.



Multiple studies in California have been published which report the savings associated with intensive treatment services which does not include the court ordered component of AOT. Such services are typically offered as a part of the spectrum of services provided via Assertive Outpatient Treatment (ACT), Assertive Community Treatment with Outreach Engagement (ACTOE), and Full Service Partnerships (FSP). Typically for every $1 spent, $1.27 in savings is yielded by effective FSP programs. Full Service Partnership programs throughout California demonstrate cost reductions in the following categories:

- Psychiatric Emergency Services
- Psychiatric Hospitalization
- Emergency Room
- Jail
- Law Enforcement

The chart below provides an overview of reported cost savings associated with AOT in Nevada County as well as the anticipated cost savings estimated by Contra Costa County.

Services	Nevada County	Contra Costa County
Inpatient hospitalization	46% decrease	23% decrease
Incarceration	65% decrease	2% decrease
Out of County IMD		60% decrease

Applying the methodology utilized to estimate cost avoidance via AOT in Contra Costa County, the following savings may be seen within Santa Barbara County via AOT implementation.

	Santa Barbara County 2014/2015 Costs	Potential Cost Avoidance	Percent Increase/Decrease
Inpatient hospitalization	$11.2Million	$2.5Million	23% decrease
Out of County IMD	$2.8 Million	$1.6 Million	60% decrease

The chart above reflects an estimate for comparison purposes. Based on the information gathered from other agencies this should not be construed as direct costs savings to occur via the implementation of full AOT. Contra Costa County has only recently implemented the program and does not have actual data to confirm the estimated cost savings.

HOW CAN AOT SERVICES BE FUNDED?

AOT has two main categories of service costs. This includes the costs associated with mental health services and the costs associated with the legal system, including the court, public defender, and county counsel. In 2013, Welfare and Institutions Code Section 5349 was amended to clarify that MHSA money can be used for court ordered AOT Services. Medi-Cal and Medi-Care revenue may also be used to offset the cost of treatment and certain forms of housing. MHSA funds may be used through Full Service Partnership programs and ACT services to fund treatment and housing pertaining to AOT. If a Board of Supervisors adopts AOT, which results in a utilization of existing Full Service Partnership programs, a community program planning process is required.

On March 24, 2015 the Board of Supervisors adopted the MHSA Plan Update for 2014/2015 and three year plan for 2015/16 to 2017/18. Although a three year plan was adopted, the MHSA plan must be updated each year. The MHSA 2015/16 Plan amendment process is anticipated to begin in July of 2015. The MHSA Plan included the provision of Full Service Partnership services within Lompoc, Santa Maria, and Santa Barbara, and supported Housing North and South FSP. From July 2013 to June 2014, these programs collectively provided services to over 470 individuals. The FSP's however contain minimal funding for housing. To ensure the appropriate level of housing is provided, per the AB1421 requirements, costs for varying levels of housing are included in both options. Further, Welfare and Institutions Code Section 5349 indicates that a Board of Supervisors must make a finding that no voluntary mental health program serving adults and no children's mental health program may be reduced as a result the implementation of this article. In regards to treatment spaces, it is anticipated that with anticipated movement of clients within FSP and ACTOE programs, individuals engaging in AOT services will be able to utilize slots provided via MHSA funds as they become available through client transition. Given the 470 slots available this level of transition is highly likely. However costs associated with the legal system including the Courts, Public Defender and County Counsel would not be eligible for MHSA funds and would require General Fund of other revenue.

SWOT Analysis New Program Implementation

Launched in June of 2013 a substantial ADMHS System Change Process has been underway to enhance collaboration with partners, and the overall service delivery to those experiencing mental illness in Santa Barbara County. The change process is designed to be outcome focused and emphasize recovery, innovation, diversity, hopefulness, service integration, complexity capable approaches to secure cultural competence. Guided by a steering committee, the department, in partnership with key stakeholders, has initiated and sustained and unprecedented work effort designed to reshape the entire system of care inclusive of voluntary outpatient and the crisis care. This work effort and the necessary programmatic and budgetary adjustment to implement the goals of system change, as adopted by the Board of Supervisors in May 2013 and further reinforced via the adoption of the 2014/2015 budget and the Mental Health Services Act Plan in March 2015, illustrate the magnitude of the system change undertaking This specifically includes the reorganization of outpatient services, new and expanded treatment services, expansion of Full Service Partnerships, redefining principles to access to services and how those services are delivered. In addition, maintaining existing effective programs and the startup of new crisis mobile, crisis triage, crisis respite and crisis stabilization programs are underway. Further, the change process addresses long standing community needs and implements the use of evidence based practices, adapted to meet the needs of individuals, including those that in the past been unserved of underserved. The Department as well the Mental Health Commission and the Behavioral Health Steering Committee have specifically engaged the work of five key action teams to aggressively work to achieve the primary findings of the TriWest Report and reported to the Board in 2013 as a part of the core of system change. These action teams include the following:

- Cultural Competency
- Children's System of Care
- Crisis Services
- Peer Integration
- Housing
- Forensics

In addition to the action teams, the Director Alcohol, Drug, & Mental Health Services recently began intensive work on access and engagement to services.

As referenced above, Option 3 discusses the capacity of the department to implement an additional program given the multiple system change activities currently underway within the ADMHS Department and the ongoing efforts to balance, stabilize, and enhance the system of care. Given the high priority of system change and the significant investment of funds and staff resources to the process it is necessary to illustrate the possible ramifications of additional program development and implementation to the core systems change effort.

The following Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis represents the potential impacts of impacts new program implementation for AOT.

SWOT ANALYSIS

STRENGTHS • **System change vision and principles consistent outreaching to all in need of care regardless of complexity and creating strong program linkages among partners** • **Strong foundation of FSP/ AOT/ACTOE services underway (MHSA)** • **Existing partnerships with court system** • **Staff capability (training and experience)**	**OPPORTUNITIES** • **Maximize system change** • **(integrated, culturally competent services, least restrictive setting, maximize outpatient system capabilities)** • **Ensure fidelity of ACT/ACTOE/FSP** • **Fully engage community in development implementation model** • **Additional mechanism for service for those not engaging and need care** • **Potential savings and or cost avoidance**
WEAKNESSES • **Capacity of existing staffing limited given attention to systems change – program expansion** • **Lack of housing supports - Gaps in service required for AOT** • **MHSA/FSP currently fully dedicated** • **Analysis presently underway of ACT model fidelity** • **2014/15 programs and facilities delayed**	**THREATS** • **Increasing demand for services outside of AOT – in patient, IST** • **Potentially divert from system change implementation – program expansion** • **Unaudited MHSA funds regarding statewide use for AOT** • **Ongoing general fund for legal costs and portion of housing costs**

In summary, the chart illustrates several weaknesses and threats:

- While the department has the capability in terms of training and experience through the provision of FSP, ACT and ACTOE programs, the overall capacity to take on additional programs beyond that detailed as part of system change is an issue and a risk for successful implementation.

- The increased demand placed on the crisis system as result of the Incompetent to Stand trial service issue state and nationwide has placed and unanticipated yet significant work effort on the department to address the demands of this new population.

- New programs could potentially divert attention from the multiple system change efforts planned or underway.

- The department is presently reviewing the ACT and ACTOE teams to ensure full fidelity to the model of services referenced previously in this report. That review will indicate if additional program refinement and changes are required to perfect those models and subsequent service delivery. Highly effective ACT/ACTOE and FSP programs are foundational to the implementation of AOT. These reviews will be complete in summer of 2015 and if necessary will inform AOT program design needs should the Board of Supervisor's direct AOT program startup.

- As a result of present staff capacity and the delay of the programs envisioned for 2014/15, including clinic reorganization, expansion of FSP's and enhancing the crisis system, the department's resources are strained. Therefore, new program implementation must ensure that impacts to existing staff and system change effort are mitigated to the fullest extent possible.

In order to mitigate impacts to system change of any new program it is critical to ensure an appropriate level of staffing. Staffing for program design as well as implementation has been considered in the costs referenced earlier in the report. In addition timing of program implementation must be considered in order to avoid impacts to system change initiatives. Given the number of new programs in development, program start up should not be considered until July of 2016. Program design is feasible during over an 8 to 10 month period of fiscal year 2015/16, if staffing is secured.

Finally given that MHSA funds have not as of this date been audited for any California county implementing AOT, great care must be taken in the actual design and implementation and data gathering of any future program to ensure no supplantation of voluntary services occur and that all tracking and reporting systems are designed to anticipate potential AOT/MHSA program audit requirements to avoid potential audit settlements in the future.

While there are threats and weaknesses inherent to any new program, the startup of AOT also has several opportunities:

- Further engagement of the community in program design and ensure that many of the programs and services within system change are achieved. This includes cultural competency, use of peers, the establishment of safe and stable housing, access to care, securing linkages and transitions through various level of care and strengthening of all programs.

- Enhancement of AOT/ACTOE & FSP programming

- Potential cost savings and/or cost avoidance to the inpatient system of care through maximizing the suite of outpatient voluntary support services identified in system change and required through AOT.

- Provides a service/treatment mechanism for those experiencing severe mental illness and opportunity for increased likelihood of successful treatment and recovery

HOW TO DETERMINE IF THE PROGRAM IS WORKING?

Performance measures associated with the assessing the efficacy of AOT would be an essential component of the program design and a key function of the proposed external program evaluator. Each county that operates AOT is required to provide data to the State Department of Mental Health. The data must include at a minimum an evaluation of:

- Reduction in homelessness
- Reduction in hospitalization
- Reduction in involvement with law enforcement

The evaluation should also include the number of persons in the program and the ability of clients to maintain housing and contact with their treatment program.

Key measures recommended therefore include:

- Psychiatric Hospitalization prior to AOT and at 12 month increments following for term of 3 years.
- Incarceration prior to AOT and at 12 month increments following for term of 3 years.
- Arrests prior to AOT and at 12 month increments following for term of 3 years.
- Emergency room visits prior to AOT and at 12 month increments following for term of 3 years.
- Homelessness prior to AOT and at 12 month increments following for term of 3 years.
- Identification of Treatment Process efficacy (what works)
- Treatment Engagement/Medication Compliance
- Employment, Education and Purposeful Activity engagement

MENTAL HEALTH COMMISSION ACTION

On March 20, 2015 the County Executive Office provided a report to the Mental Health Commission regarding the preliminary findings of the *Feasibility Analysis of AOT Implementation in Santa Barbara County*. At that time, the Commission recommended pursuing a small pilot program with the following guidelines considered:

- Ensure a system navigator overseeing program is established
- Ensure an external evaluator is utilized
- Establish a project (no term set) with the continuance contingent upon demonstration of the efficacy of the court ordered outpatient treatment

NEXT STEPS

Should the Board of Supervisors pursue one of the two implementation options, the following steps would be necessary going forward:

- Pass a resolution or ordinance at appropriate time adopting the AB1421 legislation and make a finding that no voluntary mental health program serving children or adults would be reduced as a result of implementation.
- Retain design and evaluation staff
- Develop a work group to plan, design, and implement a collaborative process and AOT program design with the community, ADMHS, the Courts, County Counsel, Public Defender, and other partner departments. It is anticipated that this process would be approximately 10 months.
- Engage in outreach efforts as set forth in AB1421 legislation to inform those likely to be in contact with AB1421 population including family members, primary care physicians, law enforcement, homeless service providers, and others.
- Identify ongoing funding sources.
- If MHSA funds are to be considered for future years, engage in the community program planning as described in the MHSA legislation (2015/2016 Plan year).

APPENDIX

SUMMARY OF WELFARE & INSTITUTIONS CODES:

- CALIFORNIA WELFARE AND INSTITUTIONS CODE §5346: CRITERIA
- CALIFORNIA WELFARE AND INSTITUTIONS CODE §5348: SERVICES
- CALIFORNIA WELFARE AND INSTITUTIONS CODE §5349: FUNDING

AB1421 TEXT

STUDIES AND RESEARCH

DETAIL OF OPTION 1 AND OPTION 2 COSTS

Summary of Welfare & Institutions Codes:

EXCERPT: CALIFORNIA WELFARE AND INSTITUTIONS CODE § 5346: CRITERIA

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

(1) The person is 18 years of age or older.

(2) The person is suffering from a mental illness as defined in paragraphs (2) and (3) of subdivision (b) of Section 5600.3.

(3) There has been a clinical determination that the person is unlikely to survive safely in the community without supervision.

(4) The person has a history of lack of compliance with treatment for his or her mental illness, in that at least one of the following is true:

(A) The person's mental illness has, at least twice within the last 36 months, been a substantial factor in necessitating hospitalization, or receipt of services in a forensic or other mental health unit of a state correctional facility or local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition.

(B) The person's mental illness has resulted in one or more acts of serious and violent behavior toward himself or herself or another, or threats, or attempts to cause serious physical harm to himself or herself or another within the last 48 months, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition.

(5) The person has been offered an opportunity to participate in a treatment plan by the director of the local mental health department, or his or her designee, provided the treatment plan includes all of the services described in Section 5348, and the person continues to fail to engage in treatment.

(6) The person's condition is substantially deteriorating.

(7) Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure the person's recovery and stability.

(8) In view of the person's treatment history and current behavior, the person is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to himself or herself, or to others, as defined in Section 5150.

(9) It is likely that the person will benefit from assisted outpatient treatment...

EXCERPT: CALIFORNIA WELFARE AND INSTITUTIONS CODE § 5348: SERVICES

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

(1) Community-based, mobile, multidisciplinary, highly trained mental health teams that use high staff-to-client ratios of no more than 10 clients per team member for those subject to court-ordered services pursuant to Section 5346.

(2) A service planning and delivery process that includes the following:

(A) Determination of the numbers of persons to be served and the programs and services that will be provided to meet their needs. The local director of mental health shall consult with the sheriff, the police chief, the probation officer, the mental health board, contract agencies, and family, client, ethnic, and citizen constituency groups as determined by the director.

(B) Plans for services, including outreach to families whose severely mentally ill adult is living with them, design of mental health services, coordination and access to medications, psychiatric and psychological services, substance abuse services, supportive housing or other housing assistance, vocational rehabilitation, and veterans' services. Plans shall also contain evaluation strategies, which shall consider cultural, linguistic, gender, age, and special needs of minorities and those based on any characteristic listed or defined in *Section 11135 of the Government Code* in the target populations. Provision shall be made for staff with the cultural background and linguistic skills necessary to remove barriers to mental health services as a result of having limited-English-speaking ability and cultural differences. Recipients of outreach services may include families, the public, primary care physicians, and others who are likely to come into contact with individuals who may be suffering from an untreated severe mental illness who would be likely to become homeless if the illness continued to be untreated for a substantial period of time. Outreach to adults may include adults voluntarily or involuntarily hospitalized as a result of a severe mental illness.

(C) Provision for services to meet the needs of persons who are physically disabled.

(D) Provision for services to meet the special needs of older adults.

(E) Provision for family support and consultation services, parenting support and consultation services, and peer support or self-help group support, where appropriate.

(F) Provision for services to be client-directed and that employ psychosocial rehabilitation and recovery principles.

(G) Provision for psychiatric and psychological services that are integrated with other services and for psychiatric and psychological collaboration in overall service planning.

(H) Provision for services specifically directed to seriously mentally ill young adults 25 years of age or younger who are homeless or at significant risk of becoming homeless. These provisions may include continuation of services that still would be received through other funds had eligibility not been terminated as a result of age.

(I) Services reflecting special needs of women from diverse cultural backgrounds, including supportive housing that accepts children, personal services coordinator therapeutic treatment, and substance treatment programs that address gender-specific trauma and abuse in the lives of persons with mental illness, and vocational rehabilitation programs that offer job training programs free of gender bias and sensitive to the needs of women.

(J) Provision for housing for clients that is immediate, transitional, permanent, or all of these.

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

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

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

(A) Live in the most independent, least restrictive housing feasible in the local community, and, for clients with children, to live in a supportive housing environment that strives for reunification with their children or assists clients in maintaining custody of their children as is appropriate.

(B) Engage in the highest level of work or productive activity appropriate to their abilities and experience.

(C) Create and maintain a support system consisting of friends, family, and participation in community activities.

(D) Access an appropriate level of academic education or vocational training.

(E) Obtain an adequate income.

(F) Self-manage their illnesses and exert as much control as possible over both the day-to-day and long-term decisions that affect their lives.

(G) Access necessary physical health care and maintain the best possible physical health.

(H) Reduce or eliminate serious antisocial or criminal behavior, and thereby reduce or eliminate their contact with the criminal justice system.

(I) Reduce or eliminate the distress caused by the symptoms of mental illness.

(J) Have freedom from dangerous addictive substances.

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

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

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

EXCERPT: CALIFORNIA WELFARE AND INSTITUTIONS CODE § 5349: FUNDING

This article shall be operative in those counties in which the county board of supervisors, by resolution or through the county budget process, authorizes its application and makes a finding that no voluntary mental health program serving adults, and no children's mental health program, may be reduced as a result of the implementation of this article. To the extent otherwise permitted under state and federal law, counties that elect to implement this article may pay for the provision of services under Sections 5347 and 5348 using funds distributed to the counties from the Mental Health Subaccount, the Mental Health Equity Subaccount, and the Vehicle License Collection Account of the Local Revenue Fund, funds from the Mental Health Account and the Behavioral Health Subaccount within the Support Services Account of the Local Revenue Fund 2011, funds from the Mental Health Services Fund when included in county plans pursuant to Section 5847, and any other funds from which the Controller makes distributions to the counties for those purposes. Compliance with this section shall be monitored by the State Department of Health Care Services as part of its review and approval of county performance contracts.

AB1421 Text

BILL NUMBER: AB 1421 CHAPTERED
BILL TEXT

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INTRODUCED BY Assembly Member Thomson
(Principal coauthor: Senator Perata)
(Coauthors: Assembly Members Aanestad, Canciamilla, Dutra, Jackson, Koretz, Longville, Richman, Salinas, and Wyland)

FEBRUARY 23, 2001

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

LEGISLATIVE COUNSEL'S DIGEST

AB 1421, Thomson. Mental health: involuntary treatment.

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

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

The program would involve the delivery of community-based care by multidisciplinary teams of highly trained mental health professionals with staff-to-client ratios of not more than 1 to 10, and additional services, as specified, for persons with the most persistent and severe mental illness. This bill would specify requirements for the petition alleging the necessity of treatment, various rights of the person who is the subject of the petition, and hearing procedures. This bill would also provide for settlement agreements as an alternative to the hearing process. This bill would provide that if the person who is the subject of the petition fails to comply with outpatient treatment, despite efforts to solicit compliance, a licensed mental health treatment provider may request that the person be placed under a 72-hour hold based on an involuntary commitment.

This bill would also require each county operating an outpatient treatment program pursuant to the bill to provide certain data to the State Department of Mental Health, and would impose requirements

upon the department to report to the Legislature, as specified.

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

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

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

(a) On February 15, 2001, the Rand Corporation released a report, commissioned by the California Senate Committee on Rules, titled "The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States," which is an evidence-based approach to examining and synthesizing empirical research on involuntary outpatient treatment.

(b) Rand's findings include the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) The person is 18 years of age or older.

(2) The person is suffering from a mental illness as defined in paragraphs (2) and (3) of subdivision (b) of Section 5600.3.

(3) There has been a clinical determination that the person is unlikely to survive safely in the community without supervision.

(4) The person has a history of lack of compliance with treatment for his or her mental illness, in that at least one of the following is true:

(A) The person's mental illness has, at least twice within the last 36 months, been a substantial factor in necessitating hospitalization, or receipt of services in a forensic or other mental health unit of a state correctional facility or local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition.

(B) The person's mental illness has resulted in one or more acts of serious and violent behavior toward himself or herself or another, or threats, or attempts to cause serious physical harm to himself or herself or another within the last 48 months, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition.

(5) The person has been offered an opportunity to participate in a treatment plan by the director of the local mental health department, or his or her designee, provided the treatment plan includes all of the services described in Section 5348, and the person continues to fail to engage in treatment.

(6) The person's condition is substantially deteriorating.

(7) Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure the person's recovery and stability.

(8) In view of the person's treatment history and current behavior, the person is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to himself or herself, or to others, as defined in Section 5150.

(9) It is likely that the person will benefit from assisted outpatient treatment.

(b) (1) A petition for an order authorizing assisted outpatient treatment may be filed by the county mental health director, or his or her designee, in the superior court in the county in which the person who is the subject of the petition is present or reasonably believed to be present.

(2) A request may be made only by any of the following persons to

the county mental health department for the filing of a petition to obtain an order authorizing assisted outpatient treatment:

(A) Any person 18 years of age or older with whom the person who is the subject of the petition resides.

(B) Any person who is the parent, spouse, or sibling or child 18 years of age or older of the person who is the subject of the petition.

(C) The director of any public or private agency, treatment facility, charitable organization, or licensed residential care facility providing mental health services to the person who is the subject of the petition in whose institution the subject of the petition resides.

(D) The director of a hospital in which the person who is the subject of the petition is hospitalized.

(E) A licensed mental health treatment provider who is either supervising the treatment of, or treating for a mental illness, the person who is the subject of the petition.

(F) A peace officer, parole officer, or probation officer assigned to supervise the person who is the subject of the petition.

(3) Upon receiving a request pursuant to paragraph (2), the county mental health director shall conduct an investigation into the appropriateness of the filing of the petition. The director shall file the petition only if he or she determines that there is a reasonable likelihood that all the necessary elements to sustain the petition can be proven in a court of law by clear and convincing evidence.

(4) The petition shall state all of the following:

(A) Each of the criteria for assisted outpatient treatment as set forth in subdivision (a).

(B) Facts that support the petitioner's belief that the person who is the subject of the petition meets each criterion, provided that the hearing on the petition shall be limited to the stated facts in the verified petition, and the petition contains all the grounds on which the petition is based, in order to ensure adequate notice to the person who is the subject of the petition and his or her counsel.

(C) That the person who is the subject of the petition is present, or is reasonably believed to be present, within the county where the petition is filed.

(D) That the person who is the subject of the petition has the right to be represented by counsel in all stages of the proceeding under the petition, in accordance with subdivision (c).

(5) The petition shall be accompanied by an affidavit of a licensed mental health treatment provider designated by the local mental health director who shall state, if applicable, either of the following:

(A) That the licensed mental health treatment provider has personally examined the person who is the subject of the petition no more than 10 days prior to the submission of the petition, the facts and reasons why the person who is the subject of the petition meets the criteria in subdivision (a), that the licensed mental health treatment provider recommends assisted outpatient treatment for the person who is the subject of the petition, and that the licensed mental health treatment provider is willing and able to testify at the hearing on the petition.

(B) That no more than 10 days prior to the filing of the petition, the licensed mental health treatment provider, or his or her designee, has made appropriate attempts to elicit the cooperation of the person who is the subject of the petition, but has not been successful in persuading that person to submit to an examination,

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

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

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

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

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

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

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

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

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

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

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

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

(F) To present evidence.

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

(H) To cross-examine witnesses.

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

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

(B) If after hearing all relevant evidence, the court finds that the person who is the subject of the petition meets the criteria for assisted outpatient treatment, and there is no appropriate and feasible less restrictive alternative, the court may order the person who is the subject of the petition to receive assisted outpatient treatment for an initial period not to exceed six months. In fashioning the order, the court shall specify that the proposed treatment is the least restrictive treatment appropriate and feasible for the person who is the subject of the petition. The order shall state the categories of assisted outpatient treatment, as set forth in Section 5348, that the person who is the subject of the petition is to receive, and the court may not order treatment that has not been recommended by the examining licensed mental health treatment provider and included in the written treatment plan for assisted outpatient treatment as required by subdivision (e). If the person has executed an advance health care directive pursuant to Chapter 2 (commencing with Section 4650) of Part 1 of Division 4.7 of the Probate Code, any directions included in the advance health care directive shall be considered in formulating the written treatment plan.

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

(e) Assisted outpatient treatment shall not be ordered unless the licensed mental health treatment provider recommending assisted outpatient treatment to the court has submitted to the court a written treatment plan that includes services as set forth in Section

5348, and the court finds, in consultation with the county mental health director, or his or her designee, all of the following:

(1) That the services are available from the county, or a provider approved by the county, for the duration of the court order.

(2) That the services have been offered to the person by the local director of mental health, or his or her designee, and the person has been given an opportunity to participate on a voluntary basis, and the person has failed to engage in, or has refused, treatment.

(3) That all of elements of the petition required by this article have been met.

(4) That the treatment plan will be delivered to the county director of mental health, or to his or her appropriate designee.

(f) If, in the clinical judgment of a licensed mental health treatment provider, the person who is the subject of the petition has failed or has refused to comply with the treatment ordered by the court, and, in the clinical judgment of the licensed mental health treatment provider, efforts were made to solicit compliance, and, in the clinical judgment of the licensed mental health treatment provider, the person may be in need of involuntary admission to a hospital for evaluation, the provider may request that persons designated under Section 5150 take into custody the person who is the subject of the petition and transport him or her, or cause him or her to be transported, to a hospital, to be held up to 72 hours for examination by a licensed mental health treatment provider to determine if the person is in need of treatment pursuant to Section 5150. Any continued involuntary retention in a hospital beyond the initial 72-hour period shall be pursuant to Section 5150. If at any time during the 72-hour period the person is determined not to meet the criteria of Section 5150, and does not agree to stay in the hospital as a voluntary patient, he or she shall be released and any subsequent involuntary detention in a hospital shall be pursuant to Section 5150. Failure to comply with an order of assisted outpatient treatment alone may not be grounds for involuntary civil commitment or a finding that the person who is the subject of the petition is in contempt of court.

(g) If the director of the assisted outpatient treatment program determines that the condition of the patient requires further assisted outpatient treatment, the director shall apply to the court, prior to the expiration of the period of the initial assisted outpatient treatment order, for an order authorizing continued assisted outpatient treatment for a period not to exceed 180 days from the date of the order. The procedures for obtaining any order pursuant to this subdivision shall be in accordance with subdivisions (a) to (f), inclusive. The period for further involuntary outpatient treatment authorized by any subsequent order under this subdivision may not exceed 180 days from the date of the order.

(h) At intervals of not less than 60 days during an assisted outpatient treatment order, the director of the outpatient treatment program shall file an affidavit with the court that ordered the outpatient treatment affirming that the person who is the subject of the order continues to meet the criteria for assisted outpatient treatment. At these times, the person who is the subject of the order shall have the right to a hearing on whether or not he or she still meets the criteria for assisted outpatient treatment if he or she disagrees with the director's affidavit. The burden of proof shall be on the director.

(i) During each 60-day period specified in subdivision (h), if the person who is the subject of the order believes that he or she is being wrongfully retained in the assisted outpatient treatment program against his or her wishes, he or she may file a petition for

a writ of habeas corpus, thus requiring the director of the assisted outpatient treatment program to prove that the person who is the subject of the order continues to meet the criteria for assisted outpatient treatment.

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

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

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

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

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

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

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

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

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

(1) Community-based, mobile, multidisciplinary, highly trained mental health teams that use high staff-to-client ratios of no more than 10 clients per team member for those subject to court-ordered services pursuant to Section 5346.

(2) A service planning and delivery process that includes the following:

(A) Determination of the numbers of persons to be served and the programs and services that will be provided to meet their needs. The local director of mental health shall consult with the sheriff, the police chief, the probation officer, the mental health board,

contract agencies, and family, client, ethnic, and citizen constituency groups as determined by the director.

(B) Plans for services, including outreach to families whose severely mentally ill adult is living with them, design of mental health services, coordination and access to medications, psychiatric and psychological services, substance abuse services, supportive housing or other housing assistance, vocational rehabilitation, and veterans' services. Plans shall also contain evaluation strategies, that shall consider cultural, linguistic, gender, age, and special needs of minorities in the target populations. Provision shall be made for staff with the cultural background and linguistic skills necessary to remove barriers to mental health services as a result of having limited-English-speaking ability and cultural differences. Recipients of outreach services may include families, the public, primary care physicians, and others who are likely to come into contact with individuals who may be suffering from an untreated severe mental illness who would be likely to become homeless if the illness continued to be untreated for a substantial period of time. Outreach to adults may include adults voluntarily or involuntarily hospitalized as a result of a severe mental illness.

(C) Provisions for services to meet the needs of persons who are physically disabled.

(D) Provision for services to meet the special needs of older adults.

(E) Provision for family support and consultation services, parenting support and consultation services, and peer support or self-help group support, where appropriate.

(F) Provision for services to be client-directed and that employ psychosocial rehabilitation and recovery principles.

(G) Provision for psychiatric and psychological services that are integrated with other services and for psychiatric and psychological collaboration in overall service planning.

(H) Provision for services specifically directed to seriously mentally ill young adults 25 years of age or younger who are homeless or at significant risk of becoming homeless. These provisions may include continuation of services that would still be received through other funds had eligibility not been terminated as a result of age.

(I) Services reflecting special needs of women from diverse cultural backgrounds, including supportive housing that accepts children, personal services coordinator therapeutic treatment, and substance treatment programs that address gender specific trauma and abuse in the lives of persons with mental illness, and vocational rehabilitation programs that offer job training programs free of gender bias and sensitive to the needs of women.

(J) Provision for housing for clients that is immediate, transitional, permanent, or all of these.

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

(3) Each client shall have a clearly designated mental health personal services coordinator who may be part of a multidisciplinary treatment team who is responsible for providing or assuring needed services. Responsibilities include complete assessment of the client's needs, development of the client's personal services plan, linkage with all appropriate community services, monitoring of the quality and follow through of services, and necessary advocacy to ensure each

client receives those services which are agreed to in the personal services plan. Each client shall participate in the development of his or her personal services plan, and responsible staff shall consult with the designated conservator, if one has been appointed, and, with the consent of the client, shall consult with the family and other significant persons as appropriate.

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

(A) Live in the most independent, least restrictive housing feasible in the local community, and, for clients with children, to live in a supportive housing environment that strives for reunification with their children or assists clients in maintaining custody of their children as is appropriate.

(B) Engage in the highest level of work or productive activity appropriate to their abilities and experience.

(C) Create and maintain a support system consisting of friends, family, and participation in community activities.

(D) Access an appropriate level of academic education or vocational training.

(E) Obtain an adequate income.

(F) Self-manage their illnesses and exert as much control as possible over both the day-to-day and long-term decisions that affect their lives.

(G) Access necessary physical health care and maintain the best possible physical health.

(H) Reduce or eliminate serious antisocial or criminal behavior, and thereby reduce or eliminate their contact with the criminal justice system.

(I) Reduce or eliminate the distress caused by the symptoms of mental illness.

(J) Have freedom from dangerous addictive substances.

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

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

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

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

(1) The number of persons served by the program and, of those, the number who are able to maintain housing and the number who maintain contact with the treatment system.

(2) The number of persons in the program with contacts with local law enforcement, and the extent to which local and state

incarceration of persons in the program has been reduced or avoided.

(3) The number of persons in the program participating in employment services programs, including competitive employment.

(4) The days of hospitalization of persons in the program that have been reduced or avoided.

(5) Adherence to prescribed treatment by persons in the program.

(6) Other indicators of successful engagement, if any, by persons in the program.

(7) Victimization of persons in the program.

(8) Violent behavior of persons in the program.

(9) Substance abuse by persons in the program.

(10) Type, intensity, and frequency of treatment of persons in the program.

(11) Extent to which enforcement mechanisms are used by the program, when applicable.

(12) Social functioning of persons in the program.

(13) Skills in independent living of persons in the program.

(14) Satisfaction with program services both by those receiving them and by their families, when relevant.

5349. This article shall be operative in those counties in which the county board of supervisors, by resolution, authorizes its application and makes a finding that no voluntary mental health program serving adults, and no children's mental health program, may be reduced as a result of the implementation of this article. Compliance with this section shall be monitored by the State Department of Mental Health as part of its review and approval of county Short-Doyle plans.

5349.1. (a) Counties that elect to implement this article, shall, in consultation with the department, client and family advocacy organizations, and other stakeholders, develop a training and education program for purposes of improving the delivery of services to mentally ill individuals who are, or who are at risk of being, involuntarily committed under this part. This training shall be provided to mental health treatment providers contracting with participating counties and to other individuals, including, but not limited to, mental health professionals, law enforcement officials, and certification hearing officers involved in making treatment and involuntary commitment decisions.

(b) The training shall include both of the following:

(1) Information relative to legal requirements for detaining a person for involuntary inpatient and outpatient treatment, including criteria to be considered with respect to determining if a person is considered to be gravely disabled.

(2) Methods for ensuring that decisions regarding involuntary treatment as provided for in this part direct patients toward the most effective treatment. Training shall include an emphasis on each patient's right to provide informed consent to assistance.

5349.5. This article shall remain in effect only until January 1, 2008, and as of that date is repealed, unless a later enacted statute that is enacted on or before January 1, 2008, deletes or extends that date.

Studies & Research

Efficacy of Assisted Outpatient Treatment (AOT)

There is no randomized control trial evidence that a court order is necessary or produces treatment compliance and good outcomes, or that a court order, in and of itself, has any independent effect on client outcomes. Research indicates that intensive long-term treatment, such as adequately resourced Assertive Community Treatment programs, results in improved clinical and outcomes.

Citation	Method	Results
Swartz, Swanson, Wagner, Burns, Hiday & Borum (1999) North Carolina	Randomized control of patients with SMI (schiz., schiz-affective, psychotic, bipolar, major depression) 264 patients in outpatient treatment or AOT for 1 year	No significant differences in hospital admissions or length of stay between groups except when treatment intensity and length considered **Key Implication**: for clients with non-affective psychotic disorders, sustained intensive outpatient treatment beyond initial court order produced significantly better hospital outcomes
Swartz, Swanson, Wagner, Burns, Hiday & Borum (2001) North Carolina	Randomized control of patients with SMI (schiz., schiz-affective, psychotic, bipolar, major depression) 331 patients released from hospital into outpatient treatment or AOT and followed for 1 year	Inpatient & Violence: sustained intensive outpatient treatment resulted in fewer hospital admissions/reduced length of stay and fewer violent incidents (minimum of three service contacts per month required). Arrests: AOT not significantly associated with fewer arrests; however patients with history of multiple hospitalizations and arrest/violence, extended outpatient commitment produced fewer arrests during study year. Victimization: extended AOT exerts indirect effect on risk of victimization via reduced violence and substance abuse and medication adherence. **Key Implication**: Medication/treatment adherence coupled with sustained intensive outpatient treatment produced better hospital, violence, arrest and victimization outcomes, not the presence of a court order.
Steadman, Gounis, Dennis, Hopper, RAOThe, Swartz & Clark Robbins (2001) New York	Randomized control of patients with SMI diagnoses (primarily psychotic) 142 patients in outpatient treatment or AOT followed for 1 year.	There were no significant differences between groups on measures of hospitalizations, arrest, quality of life, symptomatology, treatment non-compliance or perceived level of coercion. Patients in the AOT group had fewer hospitalizations while in the study compared to pre-study. **Key Implication**: court order may require patient participation, but that alone does not ensure desired outcomes.
Hiday, Swartz, Swanson, Borum, & Wagner (2002) North Carolina	Randomized control of patients with schiz., schiz-affective, psychotic, bipolar, major depression 223 patients in outpatient treatment or AOT followed for 1 year.	Participation in AOT has an unintended benefit of reducing victimization compared to clients not enrolled in AOT.

April Howard, PhD (1/27/2015)

Citation	Method	Results
Burns, Rugkasa, Molodynski, Dawson, Yeeles, Vazquez-Montes, Voysey, Sinclair & Priebe (2013) England/Wales	Randomized control of patients with psychosis diagnoses 336 patients in outpatient treatment or AOT followed for 1 year.	No significant differences were found between groups on hospital admissions, readmissions or length of stay. The groups did not differ on clinical outcomes measured by the Global Assessment of Functioning and Brief Psychiatric Rating Scales. **Key Implication**: AOT does not confer patient benefit.

Appendix: Assisted Outpatient Treatment (AOT) Research
Non-Randomized Control Studies

Study/Source	Findings
Munetz, M. R., Ritter, C., Teller, J. L. S., & Bonfine, N. (2014). Mental health court and assisted outpatient treatment: Perceived coercion, procedural justice, and program impact. *Psychiatric Services, 65*(3), 352-358.	Method: Compared interviews with people who completed AOT and graduates of mental health court (n = 52). The Mac-Arthur Admission Experience Survey was used. Results: "Mental health court graduates perceived significantly less coercion and more procedural justice in their interactions with the judge than did AOT participants. No significant difference was found between mental health court and AOT participants in perceptions of procedural justice in interactions with their case managers. Mental health court participants felt more respected and had more positive feelings about the program than did AOT participants. "
Erickson, S. K. (2004). *Outpatient commitment in new york: Examining violence, compliance and demographic characteristics of the seriously mentally ill under kendra's law* (Order No. AAI3102357).	Method: Files of 100 current and former patients of an AOT (50 current, 50 former) were reviewed for demographic data, monthly compliance records, violence, number of arrests, and incidents of interpersonal aggression. Conclusion: "Assisted Outpatient Treatment is effective at increasing certain treatment compliance, reducing acute psychiatric hospitalizations, and reducing arrests during treatment."
Swartz, M. S., Swanson, J. W., Wagner, H. R., Burns, B. J., Hiday, V. A., & Borum, R. (1999). Can involuntary outpatient commitment reduce hospital recidivism?: Findings from a randomized trial with severely mentally ill individuals. *The American Journal of Psychiatry, 156*(12), 1968-1975.	Method: Sample of mean age = 39.6 years who had been involuntarily hospitalized were randomly assigned to be released from OPC or to continue with OPC and followed for 1 year. Results: • "In bivariate analyses, the control and outpatient commitment groups did not differ significantly in hospital outcomes. However, clients who underwent sustained periods of outpatient commitment beyond that of the initial court order had approximately 57% fewer readmissions and 20 fewer hospital days than control group. Sustained outpatient commitment was shown to be particularly effective for individuals with non-affective psychotic disorders. • In repeated measures multivariable analyses, the outpatient commitment group had significantly better hospital outcomes. However, in subsequent repeated measures analyses examining the role of outpatient treatment among psychotically disordered individuals, it was also found that sustained outpatient commitment reduced hospital readmissions only when combined with a higher intensity of outpatient treatment."
Pollack, D. A., McFarland, B. H., Mahler, J. M., & Kovas, A. E. (2005). Outcomes of patients in a low-intensity, short-duration involuntary outpatient commitment program. *Psychiatric Services, 56*(7), 863-866.	Method: Control group, n = 140 (released from inpatient commitment without OPC) and Experimental group, n = 150 (admitted to OPC for 6 mos. after inpatient commitment) Results: "Patients who were in the involuntary outpatient commitment program had greater use of follow-up outpatient and residential services and psychotropic medications than patients in the comparison group. No differences were found between the groups in follow-up acute psychiatric hospitalization or arrests. Low-intensity, short-duration involuntary outpatient commitment appears to have a limited, but important, impact."
Swanson, J. W., Swartz, M. S., Elbogen, E. B., Wagner, H. R., & Burns, B. J. (2003). Effects of involuntary outpatient commitment on subjective quality of life in persons with severe mental illness. *Behavioral Sciences & the Law, 21*(4), 473-491.	Method: Control group (no OPC) and experimental group (OPC for 180+ days), n = 221. Results: "Involuntary outpatient commitment, when sustained over time, indirectly exerts a positive effect on subjective quality of life for persons with SMI, at least in part by improving treatment adherence and lowering symptomatology." (SMI = severe mental illness)

Study/Source	Findings
Compton, S., Swanson, J., Wagner, H., Swartz, M., Burns, B., & Elbogen, E. (2003). Involuntary outpatient commitment and homelessness in persons with severe mental illness. *Mental Health Services Research, 5*(1), 27-38.	Results: "This study suggests that involuntary OPC may provide a short-term reduction in the risk of homelessness among a subgroup of treatment-reluctant individuals with severe mental disorders combined with severe functional impairment."
Segal, S. P., & Burgess, P. M. (2006). The utility of extended outpatient civil commitment. *International Journal of Law and Psychiatry, 29*(6), 525-534.	"Method: Service utilization of Victorian Psychiatric Case Register (VPCR) patients with extended (≥180 day) outpatient commitment orders was compared to that of a diagnostically-matched treatment compliant group with similarly extended (≥180 day) periods of outpatient care (N = 1182)--the former receiving care during their extended episode on an involuntary basis while the latter participated in care voluntarily." Results: "Extended episodes of care for both groups were associated with subsequent reduced use of hospitalization and increases in community treatment days. Extended orders did not promote voluntary participation in the period following their termination. Community treatment days during the extended episode for those on orders were raised to the level experienced by the treatment compliant comparison group during their extended episode and maintained at that level via subsequent renewal of orders throughout the patients' careers."
Zanni, G. R., & Stavis, P. F. (2007). The effectiveness and ethical justification of psychiatric outpatient commitment. *American Journal of Bioethics, 7*(11), 31-41.	Study compared utilization of inpatient services by committed outpatients in the 1990s to outpatients not committed. Results: "Following commitment, patients had fewer hospitalizations, shorter lengths of stay, fewer seclusion episodes and hours, and fewer restraint episodes and hours."
Schneider-Braus, K. (1986). Civil commitment to outpatient psychotherapy: A case study. *Bulletin of the American Academy of Psychiatry & the Law, 14*(3), 273-279.	Method: Single-case study of 41-year old woman with severe borderline pathology. Results: "It is suggested that outpatient civil commitment may be therapeutically useful in situations such as weaning from long-term hospitalization, setting limits on violent behavior, and establishing a working relationship in the face of a patient's overwhelming negative transference feelings."
Bruce Link, Matthew Epperson, Brian Perron, Dorothy Castille, Lawrence Yang. "Arrest outcomes associated with outpatient commitment in New York State." *Psychiatric Services* 62, no. 5 (2011): 504–508.	"For those who received AOT, the odds of any arrest were 2.66 times greater ($p<.01$) and the odds of arrest for a violent offense 8.61 times greater ($p<.05$) before AOT than they were in the period during and shortly after AOT. The group never receiving AOT had nearly double the odds (1.91, $p<.05$) of arrest compared with the AOT group in the period during and shortly after assignment."
Allison Gilbert, Lorna Mower, Richard Van Dorn, Jeffrey Swanson, Christine Wilder, Pamela Clark Robbins, Karli Keator, Henry Steadman, Marvin Swartz. "Reductions in arrest under assisted outpatient treatment in New York." *Psychiatric Services* 61, no. 10 (2010): 996–999.	"The odds of arrest for participants currently receiving AOT were nearly two-thirds lower (OR=.39, $p<.01$) than for individuals who had not yet initiated AOT or signed a voluntary service agreement."
Alisa Busch, Christine Wilder, Richard Van Dorn, Marvin Swartz, Jeffrey Swanson. "Changes in guideline-recommended medication possession after implementing Kendra's Law in New York." Psychiatric Services 61, no. 10 (2010): 1000–1005.	"In all three regions, for all three groups, the predicted probability of an M(edication) P(ossession) R(atio) ≥80% improved over time (AOT improved by 31–40 percentage points, followed by enhanced services, which improved by 15–22 points, and 'neither treatment,' improving 8–19 points). Some regional differences in MPR trajectories were observed."

Study/Source	Findings
Jo Phelan, Marilyn Sinkewicz, Dorothy Castille, Steven Huz, Bruce Link. "Effectiveness and outcomes of assisted outpatient treatment in New York State." *Psychiatric Services* 61, no. 2 (2010): 137–143.	Kendra's Law has lowered risk of violent behaviors, reduced thoughts about suicide, and enhanced capacity to function despite problems with mental illness. *Patients given mandatory outpatient treatment—who were more violent to begin with—were nevertheless four times less likely than members of the control group to perpetrate serious violence* after undergoing treatment. Patients who underwent mandatory treatment reported higher social functioning and *slightly less stigma*, rebutting claims that mandatory outpatient care is a threat to self-esteem.
Marvin Swartz, Christine Wilder, Jeffrey Swanson, Richard Van Dorn, Pamela Clark Robbins, Henry Steadman, Lorna Moser, Allison Gilbert, John Monahan. "Assessing outcomes for consumers in New York's assisted outpatient treatment program." *Psychiatric Services* 61, no. 10 (2010): 976–981.	"The likelihood of psychiatric hospital admission was significantly reduced by approximately 25% during the initial six-month court order…and by over one-third during a subsequent six-month renewal of the order…. Similar significant reductions in days of hospitalization were evident during initial court orders and subsequent renewals…. Improvements were also evident in receipt of psychotropic medications and intensive case management services. Analysis of data from case manager reports showed similar reductions in hospital admissions and improved engagement in services."
Jeffrey Swanson, Richard Van Dorn, Marvin Swartz, Pamela Clark Robbins, Henry Steadman, Thomas McGuire, John Monahan. "The cost of assisted outpatient treatment: can it save states money?" *American Journal of Psychiatry* 170 (2013): 1423–1432.	In New York City **net costs declined 50%** in the first year after assisted outpatient treatment began and an additional 13% in the second year. In non-NYC counties, costs declined 62% in the first year and an additional 27% in the second year. This was in spite of the fact that psychotropic drug costs increased during the first year after initiation of assisted outpatient treatment, by 40% and 44% in the city and five-county samples, respectively. The increased community-based mental health costs were more than offset by the reduction in inpatient and incarceration costs. Cost declines associated with assisted outpatient treatment were about twice as large as those seen for voluntary services.[1]
Department of Justice. "Crime solutions: assisted outpatient treatment." *Crime Solutions.gov.* 2012.	Assisted outpatient treatment is an effective crime prevention program.
Jeffrey Swanson, Richard Van Dorn, Marvin Swartz, Andrew Cislo, Christine Wilder, Lorna Moser, Allison Gilbert, Thomas McGuire. "Robbing Peter to pay Paul: did New York State's outpatient commitment program crowd out voluntary service recipients?" Psychiatric Services 61, no. 10 (2010): 988–995.	"In tandem with New York's AOT program, enhanced services increased among involuntary recipients, whereas no corresponding increase was initially seen for voluntary recipients. In the long run, however, overall service capacity was increased, and the focus on enhanced services for AOT participants appears to have led to greater access to enhanced services for both voluntary and involuntary recipients."
Richard Van Dorn, Jeffrey Swanson, Marvin Swartz, Christine Wilder, Lorna Moser, Allison Gilbert, Andrew Cislo, Pamela Clark Robbins. "Continuing medication and hospitalization outcomes after assisted outpatient treatment in New York" Psychiatric Services 61, no. 10 (2010): 982–987.	Individuals in AOT stay in treatment after AOT ends. "When the court order was for seven months or more, improved medication possession rates and reduced hospitalization outcomes were sustained even when the former AOT recipients were no longer receiving intensive case coordination services."
Marvin Southard. "Assisted Outpatient Treatment Program Outcomes Report." Department of Mental Health, Los Angeles County, Los Angeles, CA, February 24, 2011.	In Los Angeles, CA, the AOT pilot program reduced incarceration 78%, hospitalization 86%, hospitalization after discharge from the program 77%, and cut taxpayer costs 40%.

[1] Various opponents of Assisted Outpatient Treatment claimed that New York State invested millions of dollars in increased services before implementing AOT. When Kendra's Law was passed in New York, funding for other programs not related to Kendra's Law were attached to the bill. Of the $132 million, only $6.62 million (after Medicaid match) was for Kendra's Law. (data on file with author).

Study/Source	Findings
New York State Office of Mental Health. Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment. Report to Legislature, Albany: New York State, 2005, 60.	**Danger and violence reduced** • 55% fewer recipients engaged in suicide attempts or physical harm to self • 47% fewer physically harmed others • 46% fewer damaged or destroyed property • 43% fewer threatened physical harm to others • Overall, the average decrease in harmful behaviors was 44% **Consumer outcomes improved** • 74% fewer participants experienced homelessness • 77% fewer experienced psychiatric hospitalization • 56% reduction in length of hospitalization. • 83% fewer experienced arrest • 87% fewer experienced incarceration • 49% fewer abused alcohol • 48% fewer abused drugs **Consumer participation and medication compliance improved** • The number of individuals exhibiting good adherence to meds increased 51% • The number of individuals exhibiting good service engagement increased 103% **Consumer perceptions were positive** • 75% reported that AOT helped them gain control over their lives • 81% said AOT helped them get and stay well • 90% said AOT made them more likely to keep appointments and take meds • 87% of participants said they were confident in their case manager's ability • 88% said they and their case manager agreed on what was important to work on **<u>Effect on mental illness system</u>** "**Improved access to services.** AOT has been instrumental in increasing accountability at all system levels regarding delivery of services to high need individuals. Community awareness of AOT has resulted in increased outreach to individuals who had previously presented engagement challenges to mental health service providers." "**Improved treatment plan development, discharge planning, and coordination of service planning.** Processes and structures developed for AOT have resulted in improvements to treatment plans that more appropriately match the needs of individuals who have had difficulties using mental health services in the past." "**Improved collaboration between mental health and court systems.** As AOT processes have matured, professionals from the two systems have improved their working relationships, resulting in greater efficiencies, and ultimately, the conservation of judicial, clinical, and administrative resources. • There is now an organized process to prioritize and monitor individuals with the greatest need; • AOT ensures greater access to services for individuals whom providers have previously been reluctant to serve; • There is now increased collaboration between inpatient and community-based providers."

Study/Source	Findings
Marvin Swartz, Christine Wilder, Jeffrey Swanson, Richard Van Dorn, Pamela Clark Robbins, Henry Steadman, Lorna Moser, Allison Gilbert, John Monahan. "Assessing outcomes for consumers in New York's assisted outpatient treatment program." *Psychiatric Services* 61, no. 10 (2010): 976–981. Marvin Swartz, Jeffrey Swanson, Henry Steadman, Pamela Clark Robbins, JohnMonahan. "New York State assisted outpatient treatment program evaluation." Duke University School of Medicine, Durham, NC, 2009.	"We find that New York State's AOT Program improves a range of important outcomes for its recipients, apparently without feared negative consequences to recipients." • **Racial neutrality**: "We find no evidence that the AOT Program is disproportionately selecting African Americans for court orders, nor is there evidence of a disproportionate effect on other minority populations. Our interviews with key stakeholders across the state corroborate these findings." • **Court orders add value:** "The increased services available under AOT clearly improve recipient outcomes, however, the AOT court order, itself, and its monitoring do appear to offer additional benefits in improving outcomes." • **AOT improves the likelihood that providers will serve seriously mentally ill:** "It is also important to recognize that the AOT order exerts a critical effect on service providers stimulating their efforts to prioritize care for AOT recipients." • **AOT improves service engagement:** "After 12 months or more on AOT, service engagement increased such that AOT recipients were judged to be more engaged than voluntary patients. This suggests that after 12 months or more, when combined with intensive services, AOT increases service engagement compared to voluntary treatment alone." • **Consumers Approve**: "Despite being under a court order to participate in treatment, current AOT recipients feel neither more positive nor more negative about their treatment experiences than comparable individuals who are not under AOT."
Michael Heggarty. "The Nevada County Laura's Law experience." Behavioral Health Department, Nevada County, Nevada County, CA, November 15, 2011.	In Nevada County, CA, AOT ("Laura's Law") decreased the number of Psychiatric Hospital Days 46.7%, the number of Incarceration Days 65.1%, the number of Homeless Days 61.9%, and the number of Emergency Interventions 44.1%. Laura's Law implementation saved $1.81–$.2.52 for every dollar spent, and receiving services under Laura's Law caused a "reduction in *actual* hospital costs of $213,300" and a "reduction in *actual* incarceration costs of $75,600."
Virginia Hiday, and Teresa Scheid-Cook. "The North Carolina experience with outpatient commitment: a critical appraisal." *International Journal of Law and Psychiatry* 10, no. 3 (1987): 215–232.	In North Carolina, AOT reduced the percentage of persons refusing medications to 30%, compared to 66% of patients not under AOT.
Mark Munetz, Thomas Grande, Jeffrey Kleist, Gregory Peterson. "The effectiveness of outpatient civil commitment." *Psychiatric Services* 47, no. 11 (1996): 1251–1253.	In Ohio, AOT increased attendance at outpatient psychiatric appointments from 5.7 to 13.0 per year. It increased attendance at day treatment sessions from 23 to 60 per year. "During the first 12 months of outpatient commitment, patients experienced significant reductions in visits to the psychiatric emergency service, hospital admissions, and lengths of stay compared with the 12 months before commitment."
Robert Van Putten, Jose Santiago, Michael Berren. "Involuntary outpatient commitment in Arizona: a retrospective study." *Hospital and Community Psychiatry* 39, no. 9 (1988): 953–958.	In Arizona, "71% [of AOT patients] . . . voluntarily maintained treatment contacts six months after their orders expired" compared with "almost no patients" who were not court-ordered to outpatient treatment.

Study/Source	Findings
Barbara Rohland. "The role of outpatient commitment in the management of persons with schizophrenia." Iowa Consortium for Mental Health Services, Training and Research, 1998.	In Iowa, "it appears as though outpatient commitment promotes treatment compliance in about 80% of patients… After commitment is terminated, about 3/4 of that group remain in treatment on a voluntary basis."
Treatment Advocacy Center. "Success of AOT in New Jersey 'Beyond Wildest Dreams.'" Treatment Advocacy Center. September 2, 2014.	In New Jersey, Kim Veith, director of clinical services at Ocean Mental Health Services, noted the AOT pilot program performed "beyond wildest expectations." AOT reduced hospitalizations, shortened inpatient stays, reduced crime and incarceration, stabilized housing, and reduced homelessness. Of clients who were homeless, 20% are now in supportive housing, 40% are in boarding homes, and 20% are living successfully with family members.
Virginia Hiday, Marvin Swartz, Jeffrey Swanson, Randy Borum, H. Ryan Wagner. "Impact of outpatient commitment on victimization of people with severe mental illness." *American Journal of Psychiatry* 159, no. 8 (2002): 1403–1411.	"Subjects who were ordered to outpatient commitment were less likely to be criminally victimized than those who were released without outpatient commitment."
Jeffrey Swanson, Marvin Swartz, Richard Van Dorn, John Monahan, Thomas McGuire, Henry Steadman, Pamela Clark Robbins. "Racial disparities in involuntary outpatient commitment: are they real?" *Health Affairs* 28, no. 3 (2009): 816–826.	"We found no evidence of racial bias. Defining the target population as public-system clients with multiple hospitalizations, the rate of application to white and black clients approaches parity."
Swartz, M. S., & Swanson, J. W. (2004). Involuntary outpatient commitment, community treatment orders, and assisted outpatient treatment: What's in the data? *The Canadian Journal of Psychiatry / La Revue Canadienne De Psychiatrie, 49*(9), 585-591.	Method: Review of all English-language studies of OPC available from Medline Results: "Existing naturalistic and quasi-experimental studies, taken as a whole, moderately support the view that the procedure is effective, although all do have methodological limitations." • Most effective if OPC last for 6+ months • OPC only effective if combined with frequent services • Most effective on patients with psychotic disorders

Efficacy of Outpatient Commitment (OC)

There is no empirical evidence that a court order is necessary or produces treatment compliance and good outcomes, or that a court order, in and of itself, has any independent effect on client outcomes. Research indicates that intensive long-term treatment, such as adequately resourced Assertive Community Treatment programs, results in improved clinical and outcomes.

Citation	Method	Results
Swartz, Swanson, Wagner, Burns, Hiday & Borum (1999) North Carolina	Randomized control of patients with SMI (schiz., schiz-affective, psychotic, bipolar, major depression) 264 patients in outpatient treatment or OC for 1 year	No significant differences in hospital admissions or length of stay between groups except when treatment intensity and length considered **Key Implication**: for clients with non-affective psychotic disorders, sustained intensive outpatient treatment beyond initial court order produced significantly better hospital outcomes
Swartz, Swanson, Wagner, Burns, Hiday & Borum (2001) North Carolina	Randomized control of patients with SMI (schiz., schiz-affective, psychotic, bipolar, major depression) 331 patients released from hospital into outpatient treatment or OC and followed for 1 year	Inpatient & Violence: sustained intensive outpatient treatment resulted in fewer hospital admissions/reduced length of stay and fewer violent incidents (minimum of three service contacts per month required). Arrests: OC not significantly associated with fewer arrests; however patients with history of multiple hospitalizations and arrest/violence, extended outpatient commitment produced fewer arrests during study year. Victimization: extended OC exerts indirect effect on risk of victimization via reduced violence and substance abuse and medication adherence. **Key Implication**: Medication/treatment adherence coupled with sustained intensive outpatient treatment produced better hospital, violence, arrest and victimization outcomes, not the presence of a court order.
Steadman, Gounis, Dennis, Hopper, Roche, Swartz & Clark Robbins (2001) New York	Randomized control of patients with SMI diagnoses (primarily psychotic) 142 patients in outpatient treatment or OC followed for 1 year.	There were no significant differences between groups on measures of hospitalizations, arrest, quality of life, symptomatology, treatment non-compliance or perceived level of coercion. Patients in the OC group had fewer hospitalizations while in the study compared to pre-study. **Key Implication**: court order may require patient participation, but that alone does not ensure desired outcomes.
Burns, Rugkasa, Molodynski, Dawson, Yeeles, Vazquez-Montes, Voysey, Sinclair & Priebe (2013) England/Wales	Randomized control of patients with psychosis diagnoses 336 patients in outpatient treatment or OC followed for 1 year.	No significant differences were found between groups on hospital admissions, readmissions or length of stay. The groups did not differ on clinical outcomes measured by the Global Assessment of Functioning and Brief Psychiatric Rating Scales. **Key Implication**: OC does not confer patient benefit.

Detail of Option 1 and Option 2 Costs

DEPARTMENT OF MENTAL HEALTH
SANTA BARBARA COUNTY
VOLUNTARY AOT IMPLEMENTATION MODEL PROJECT -Evlauation of 75 individuals

EOB ITEM & DESCRIPTION	FTE	YEARLY SALARY	SALARY SAVINGS 0.0000%	NET SALARY	EB RATE 74.4800%	TOTAL S&EB
TEAM SUPERVISOR - PSYCHOLOGIST	1	88,629	-	88,629	66,011	154,640
PSYCHOLOGIST I	1	76,490		76,490	56,970	133,460
ADMIN OFFICE PROFESSIONAL I	0.25	8,726	-	8,726	6,499	15,225
	2.25					
		TOTAL S&EB	-	173,845	129,480	**303,325**

SERVICES & SUPPLIES DESCRIPTION	UNIT COST
Computers	2,802
County Telephone	1,920
Local Printer	6,000
Mileage	1,000
Office Supplies	2,400
Space	24,000
Telecommunication (Cell phone)	1,920
Training	4,000
Utilities	3,600
Contract Evaluator	40,000
TOTAL S & S	**87,642**

START UP - CAPITAL ASSETS / FACILITY	QTY	TOTAL
Vehicles	1	**30,000**
Establish Facility	1	**150,000**
TOTAL START UP - CAPITAL ASSET/FACILITY		**180,000**

ADMINISTRATIVE COSTS	UNIT COST
Administrative Overhead (estimate 15%)	85,645
TOTAL ADMINISTRATIVE COSTS	**85,645**

Total Staff & Operation Costs:	**$ 656,612**

Total Legal and Court Costs	**$ 265,000**

Treatment Description	Gross Cost	Net Cost*	Unit Number	Gross Total	Net Total
FSP Slot voluntary	28,585	14,864	19	543,115	282,420
FSP slots Involuntary	28,585	14,864	19	543,115	282,420
Housing - Single Bedroom Apartment	15,000	15,000	10	150,000	150,000
Housing Board and Care		8,280	8		66,240
Housing - IMD Step Down Beds	100,000	100,000	1	100,000	100,000
Enhanced Programming			38	200,000	124,000
			Totals:	**1,536,230**	**1,005,080**

*Net Cost for FSP and Enhanced programming assumes 48% reimbursement (20% are indigent and then 80% have Medi-Cal with 60% reimbursement of those costs)

*No net cost for IMD step down. This is only calculated as Gross. Assume Crisis Residential at contract rate of $100k/yr.

*No net costs for Single Bedroom Apartment, assume $1250 per studio per month

*Evaluate 75, 50% qualify for program in FSP level of care

Program Costs (Itemized)	Cost	Notes
Total S&EB	303,325	
Total S&S	87,642	
Total Start Up - Capital Assets & Facility	180,000	
Total Administrative Costs	85,645	
Total Legal and Court Costs	265,000	
Housing - Single Bedroom Apartments	150,000	
Housing - IMD Step Down Cost	100,000	
Housing Board and Care	66,240	
Enhanced Programming	124,000	
FSP Net Cost Vol	282,420	
FSP Net Cost Invol	282,420	
Total Net Program	**1,926,691**	
FSP Treatment Revenue	260,695	Medi-Cal Reimbursement
Enhanced Programming Revenue	76,000	Medi-Cal Reimbursement
Total Gross Program	**2,263,387**	
Total Cost Per Client	**30,178**	75 starting, average cost

MHSA Eligible	$ 1,345,451
Non MHSA (legal)	$ 265,000
Non MHSA Housing	$ 316,240
FSP Treatment	$ 260,695
Program Revenue	$ 76,000
	$2,263,387

DEPARTMENT OF MENTAL HEALTH
SANTA BARBARA COUNTY
VOLUNTARY AOT MODEL PROJECT - 10 person pilot

EOB ITEM & DESCRIPTION	FTE	YEARLY SALARY	SALARY SAVINGS 0.0000%	NET SALARY	EB RATE 74.4800%	TOTAL S&EB
TEAM SUPERVISOR - PSYCHOLOGIST	0.5	44,300	-	44,300	32,995	77,295
ADMIN OFFICE PROFESSIONAL I	0.25	8,726	-	8,726	6,499	15,225
	0.75					
		TOTAL S&EB	-	53,026	39,494	**92,520**

SERVICES & SUPPLIES DESCRIPTION	UNIT COST
Computers	2,802
County Telephone	1,920
Local Printer	1,000
Mileage	1,000
Office Supplies	2,400
Space	24,000
Telecommunication (Cell phone)	1,920
Training	4,000
Contract Evaluation	10,000
Utilities	3,600
TOTAL S & S	**52,642**

START UP - CAPITAL ASSETS / FACILITY	QTY	TOTAL	
Vehicles	1	**3,000**	
Establish Facility	1	-	*Use current facilities
TOTAL START UP - CAPITAL ASSET/FACILITY		**3,000**	

ADMINISTRATIVE COSTS	UNIT COST
Administrative Overhead (estimate 15%)	22,224
TOTAL ADMINISTRATIVE COSTS	**22,224**

Total Staff & Operation Costs:	**$**	**170,386**

Total Legal and Court Costs	**$**	**10,000**

Treatment Description	Gross Cost	Net Cost*	Unit Number	Gross Total	Net Total
FSP Slot voluntary	28,585	14,864	5	142,925	74,321
FSP Slot involuntary	28,585	14,864	5	142,925	74,321
Housing - Single Bedroom Apartment	15,000	15,000	2	30,000	30,000
Housing - IMD Step Down Beds	100,000	100,000	1	100,000	100,000
Housing Board and Care		8,260	1		8,260
Enhanced Programming				30,000	18,600
			Totals:	**445,850**	**305,502**

10 person pilot

*Net Cost for FSP assumes 48% reimbursement (20% are indigent and then 80% have Medi-Cal with 60% reimbursement of those costs)

*No net cost for IMD step down. This is only calculated as Gross. Assume Crisis Residential at contract rate of $100k/yr.

*No net costs for Single Bedroom Apartment, assume $1250 per studio per month

Program Costs (Itemized)	Cost	Notes
Total S&EB	92,520	
Total S&S	52,642	
Total Start Up - Capital Assets & Facility	3,000	
Total Administrative Costs	22,224	
Total Legal and Court Costs	10,000	
Housing - Single Bedroom Apartments	30,000	
Housing - IMD Step Down Cost	100,000	
Housing Board and Care	8,260	
Enhanced Programming	18,600	
FSP Net Cost vountary	74,321	
FSP involuntary	74,321	
Total Net Program	**485,888**	
FSP Treatment Revenue	137,208	Medi-Cal Reimbursement
Enhanced Programming Revenue	11,400	Medi-Cal Reimbursement
Total Gross Program	**634,496**	
Total Cost Per Client	**63,450**	10 person pilot cost per person

MHSA Eligible	$	337,628
Non MHSA (legal)	$	10,000
Non MHSA Housing	$	138,260
FSP Treatment	$	137,208
Program Revenue	$	11,400
	$	**634,496**